University of Alberta

Can Psychologists Identify When the Problem is Cybersex Addiction?:
An Exploratory Study

by

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Dedication

I dedicate this research study to all individuals with cybersex addiction who have searched unsuccessfully for a clinician who can truly understand and help them. I hope this study goes a little way towards increasing the odds of finding one.

Abstract

Clients with cybersex addiction (CSA) are a growing challenge for mental health practitioners. Therapists must be more skilled and adept at identifying when the core issue is cybersex addiction in spite of client denial and potentially confounding symptoms. The main purpose of this exploratory research was to determine whether psychologists can identify when the presenting problem is cybersex addiction among non-disclosing clients. A pilot was conducted with 10 doctoral-level graduate students in psychology and three Expert Validators to evaluate the construct validity and internal reliability of the Client Vignette Scoring Instrument (CVSI) created for this study. The CVSI provided participants with three fictional case vignettes which each incorporated a specific number of CSA criteria. The case of "Jeff" included no CSA symptoms, "Sophie" included the minimum required for diagnosis, and "Bill" included the maximum. Psychologists were then recruited via the CPA and the PAA online and by mail, resulting in a final sample of 93 participants. Three surveys were administered: the CVSI, a Modified Sexual Opinion Survey-Revised (SOS-R-M), and a demographic survey. Alpha was set at .10. Results of a chi-square test for goodness of fit indicated that a significant proportion of psychologists missed correctly identifying CSA as the primary presenting problem in the case of both Sophie and Bill, but correctly avoided identifying CSA as the primary presenting problem in the case of Jeff. Results of a multiple linear regression found no significant predictive model in any of the three cases for the IVs age, number of years in practice, Internet familiarity, sexual attitude and amount of training in

CSA/SA on the outcome variable perception of CSA symptoms. Neither age, sexual attitude, gender, nor province of registration had a significant effect on perception of CSA symptoms in any of the cases. Doctoral level psychologists had significantly lower scores on the outcome variable than Master's level in all cases. Implications of the findings are discussed.

Acknowledgement

In so much as it takes a village to raise a child, and in so much as the experience of writing a dissertation is like birthing a child into the world, it takes a village to help birth a dissertation. There are so many people to thank for helping me complete this part of my Ph.D. requirements. I want to thank Gretchen Hess, who was in the role of my supervisor up until my candidacy and challenged me to write with clarity and concision. George Buck, my supervisor from candidacy till the completion of this document, has been encouraging, respectful, supportive and kind and for his understanding I owe him a great deal of thanks. The rest of my committee members – Dr. William Whelton, Dr. Shaniff Esmail, Dr. Sophie Yohani, Dr. Jim Eliuk, and Dr. Maryanne Doherty-Poirier – I thank you for your thoroughness in reviewing my research and your patience as I worked through what was a tremendous undertaking for me. To Dr. Derek Truscott, my gratitude for taking the time to consult with me as I tried to make sense of my findings. I want to thank Mary Roduta Roberts for her patience and calmness in the face of my myriad of emails and phone calls about yet another statistical question. You always explained clearly and kindly and I always felt a little smarter after talking to you. To my dear, dear friend and colleague Sherry Antonnucci I extend the warmest thanks for the many kindnesses and the gentle way with which you nudged and encouraged me and told me you had faith in me when I really thought I couldn't write or read one more sentence. To my parents and my whole family, I thank you for your endurance as I plowed through foreign sounding doctoral requirements and avoided your inquiries into when I would be done. To my sister

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List of Acronyms, Symbols, Nomenclature or Abbreviations

CVSI – Client Vignette Scoring Instrument

CVSI-V1 – Client Vignette Scoring Instrument, Version 1

CVSI-V2 – Client Vignette Scoring Instrument, Version 2

CVSI-V3 – Client Vignette Scoring Instrument, Version 3

EV – Expert Validator

SOS – Sexual Opinion Survey

SOS-R – Revised Sexual Opinion Survey

SOS-R-M – Modified Revised Sexual Opinion Survey

CSA – Cybersex Addiction

SA – Sex Addiction

MDD – Major Depressive Disorder

OCD – Obsessive Compulsive Disorder

DSM-III – Diagnostics and Statistical Manual Third Edition

DSM-IV – Diagnostics and Statistical Manual Fourth Edition

DSM-IV-TR – Diagnostics and Statistical Manual Fourth Edition Revised

DSM-5 – Diagnostics and Statistical Manual Fifth Edition

Chapter 1 – Introduction

Clients with *cybersex addiction* are a growing challenge for mental health practitioners (Freeman-Longo, 2000; Young, 2001). Cybersex is any digitalized visual, auditory or written sexual content accessed for the purpose of sexual arousal and stimulation via Internet connection, or as data retrieved by computer (Schneider & Weiss, 2001). Indeed the Internet, first created in 1969 (Elon University School of Communications and the Pew Internet and American Life Project, n.d.) as a communications tool by the U.S. Department of Defence in the event of a nuclear disaster, has surpassed its simple, mostly text-based beginnings and is no longer a tool of only the techno-elite or specialist. As of 2009 Internet users worldwide exceeded 1.83 billion, which shows a marked and rapid increase from 2000 and 2005 figures of merely 430 million and 1.09 billion, respectively (ETForecasts, 2010). Canada alone boasts a total of 27.12 million Internet users, making it one of the top 15 countries in terms of Internet usage (ETForecasts, 2010).

In 2009, more than three-quarters of Canadians used the Internet, with an estimated 21.7 million (80%) adult Canadians using the Web for personal non-business-related reasons, which is up from 73% in 2007 and 68% in 2005 (Statistics Canada, 2010a). Of those who used the Internet from home, three-quarters (approximately 15.6 million) used it every day (Statistics Canada, 2010a; Statistics Canada, 2010b) and 55% (10.2 million) accessed the Internet for five or more hours per week (Statistics Canada, 2010a). Among 16 to 24-year-olds, 98% were going online as of 2009, and two-thirds of those aged 45 or older were also

online in 2009 and made up 60% of all new Internet users from the previous two years (Statistics Canada, 2010a). Usage based on gender was similar in 2009, with 81% of males and 80% of females logging on (Statistics Canada, 2010a). Among Canadians, number of years online appears to be positively correlated with a wider range of online activities (Statistics Canada, 2010a), and level of education completed shows a positive correlation with Internet use (Statistics Canada, 2010c). In contrast, age shows a negative correlation with the Internet usage (Statistics Canada, 2010b). The size of the Internet has been estimated to be increasing by 25% every three months (Carnes, Delmonico, Griffin, & Moriarty, 2001; Cooper, 1998).

It appears that a major interest for many individuals when logged on is sex. Twenty percent of all Internet users are estimated to engage in some form of online sexual activity (Cooper, Delmonico, & Burg, 2000). In fact, the word "sex" is the most searched-for term on the Internet (Cooper, 1998; Freeman-Longo & Blanchard, 1998). By 2001 some estimated that the online pornography industry had reached $1 billion (Griffiths, 2001), but by 2006 it exceeded $2.8 billion in just the United States not including mobile phone revenues ("Internet pornography," 2006). By 1999 alone 69% of all e-commerce (Fisher & Barak, 2001) and more than 50% of all dollars spent online (Cooper, Griffin-Shelley, Delmonico, & Mathy, 2001; Sprenger, 1999; Yoder, Virden III, & Amin, 2005) were estimated to involve the purchase of online sexual activities and materials. Every second $3,075.64 is spent on online pornography ("Internet pornography," 2006) and worldwide Internet pornography sales total $4.9 billion (Ropelato,

2011). In 2013, 450 million unique visitors per month accessed online pornography, which is more than those who accessed Netflix, Amazon.com and Twitter combined ("Porn sites," 2013). In 2006, 72 million Internet users worldwide visited some of the 4.2 million pornographic websites (approximately 12% of all websites) monthly (Ropelato, 2011; "Internet pornography, " 2006). According to Google's Ad Planner system, which tracks specific website users with cookies, just one pornography website can make up about 2% of all Internet traffic and it has been proposed that 30% of all data transferred via the Internet is pornography related (Anthony, 2012, p. 2).

Of those who are accessing sexual content on the Internet, 17% are experiencing problems with their online sexual behaviour (detailed further in the definitions section), and 8% are referred to as *heavy users* displaying online sexual compulsivity and spending between 11 and more than 80 hours online engaged in sexual behaviour per week (Cooper, Scherer, Boies, & Gordon, 1999). If we take 8% of the population of adult online sex users in Canada alone, this suggests that almost 2.7 million Canadians may be struggling with online sexual compulsivity. Based on these figures we can see why it is likely that the number of clients presenting for counselling with this issue is likely to increase over time, and why counsellors must be prepared to deal with this issue in therapy (Carnes et al., 2001; Cooper et al., 2000; Cooper et al., 2001; Griffiths, 2001).

Problem

Cybersex addicts rarely seek therapy (Putnum & Maheu, 2000) and when they do, 20% do not disclose their compulsive cybersex use (Cooper, Scherer, et

al., 1999; Goldberg, 2004). Unfortunately, because shame is often a core part of cybersex addiction (Adams & Robinson, 2001; Cooper, Putnam, Planchon, & Boies, 1999; Putnam, 2000; Reed, 2000; Schwartz & Southern, 2000; Weiss, n.d.; Young, 1991), and because shame leads to denial (Adams & Robinson, 2001; MacDonald, 1998), when clients with cybersex addiction do make it to therapy they rarely disclose their online sexual acting out to therapists (Adams & Robinson, 2001; Greenfield & Orzack, 2002). Cybersex addicts' online sexual acting out can include compulsively using dating websites, message boards, erotic chat, live web cams, still images, streaming video, mobile phone apps, Facebook, chat roulette, instant messaging (IM), etc., as both sexual ends unto themselves as well as means that lead to real-time sexual encounters with others (Bosker, 2010; Carnes et al., 2001; Lazar, 2010 as cited in Weiss & Samenow, 2010; Schneider & Weiss, 2001; Smith, 2010; Weiss & Samenow, 2010; Weiss & Schneider, 2006; Yassa, 2006, 2008; Young, 2001). When cybersex addicted clients do disclose their online sexual behaviour, they often do not attribute the consequences of their addiction (i.e., relational, financial, employment, marital, criminal) to their sexual acting out (Ayers & Haddock, 2009; Cooper, Putnam, et al., 1999; Cooper, Scherer, et al., 1999; Greenfield & Orzack, 2002). As a result, therapists must be more skilled and adept at identifying when the core issue is cybersex addiction (Ayers & Haddock, 2009; Delmonico, 2002).

A person’s sexual attitudes, however, can shape their biases towards sexual behaviours (Ayers & Haddock, 2009; Fisher, White, Byrne, & Kelley, 1988; Murray, Ciarrocchi, & Murray-Swank, 2007; Schnarch, 1992; Schover,

1981; Swisher, 1995) and level of comfort with sexual material (Ayers & Haddock, 2009; Byrne, 1982; Fisher, White, et al., 1988; Kelley, 1985; Schover, 1981). For example, research has found that therapists' personal characteristics (Hersoug, 2004; Smith, 2003; Barry, 1999; Elkin, 1999), shame levels (Hastings, 1998), religion, gender, attitudes and values (Ayres & Haddock, 2009; Carlson & Erickson, 1999; Hecker, Trepper, Wetchler, & Fontaine, 1995; Schover, 1981) all influence their diagnosis, treatment and therapeutic outcome. It is possible that these variables could impede therapists from asking the important questions regarding their clients' sexual history, accurately perceiving the problem in need of therapeutic attention (Ayers & Haddock, 2009) and, ultimately, the outcome of therapy (Smith, 2003). Therefore, therapists' attitudes about sexual matters could influence their ability to explore and detect sexual problems in their clients.

Purpose

Sadly, many clients who have sought help for their cybersex addiction have reported having had to see many therapists before their cybersex addiction was addressed (Schneider, 2002; Weiss & Schneider, 2006). In some cases, clients reported a lack of acknowledgment by the therapist that their sexual acting-out constituted a problem, let alone an addiction (Schneider, 2000a; Weiss & Schneider, 2006). The obvious results of this are wasted time and effort on the part of both the client and the therapist, wasted money on the part of the client, and often worsening of the cybersex addiction symptoms (Schneider, 2000a; Weiss & Schneider, 2006). Determining whether therapists can indeed identify when the presenting problem is cybersex addiction then becomes an important

area of research and is the intended focus of this study. Furthermore, identifying to what degree, if any, personal and professional characteristics, including sexual attitudes, might play a role in therapists' perceptions of the presenting problem among cybersex addicted clients becomes relevant, and will also be addressed in this study.

Overview of Study and Research Questions

Crotty (1998) outlines the importance of situating one's research study in relation to four foundational elements of the research process: epistemology, theoretical perspective, methodology, and method. According to Crotty (1998), "...to talk of the construction of meaning [epistemology] is to talk of the construction of meaningful reality [ontology]" (p. 10), which is the argument he puts forward for why ontology does not feature in the four basic elements. For this study, the ontological lens and epistemological framework can be described as Objectivist Critical Realism. Objectivism holds that a meaningful reality exists outside of consciousness and can be accessed and understood using correct methods (Crotty, 1998; Robson, 2002), while Critical Realism indicates this reality can only be imperfectly known, understood and approximated, and therefore not proven, due to the limitations of being human (Denzin & Lincoln, 2005; Robson, 2002). From within this stance on knowledge theory the theoretical perspective underlying this study and guiding methodological selection is that of post-positivism. Post-positivism allows for researcher impetus and influence and holds that knowledge is not now nor has ever been unbiased and is instead constructed socially (Robson, 2002; Ryan, 2006). The methodology

applied herein is that of survey research, and it involves the research methods selected of convenience sampling, questionnaires and statistical analysis.

In order to establish whether therapists can identify when the presenting problem is cybersex addiction, it is necessary to first establish what is meant by the term *cybersex addiction* (CSA). To address this, a review of the literature surrounding the disorder was conducted, in addition to exploring the debate that surrounds this construct. Since the inception of the construct "sex addiction" (SA[1]), much debate has circulated around whether the disorder can indeed be categorized as an addiction (Briken, Habermann, Berner, & Hill, 2007; Carnes et al., 2001; Goodman, 1998c; Goodman, 2001; Katehakis, 2012; Kor, Fogel, Reid, & Potenza, 2013; Samenow, 2010a; Weiss & Schneider, 2006), a compulsion (Goodman, 2001; Quadland, 1985; Weissberg & Levay, 1986), an impulsivity disorder (Barth & Kinder, 1987; Goodman, 2001), or something else entirely (Kafka, 1997; Kafka, 2001; Kafka, 2007; Kafka, 2010; Kafka, 2013; Kafka & Hennen, 1999; Kafka & Hennen, 2003; Kingston & Firestone, 2008; Young, 1999; Young, 2001). In this investigation, the diagnostic label of "cybersex addiction" is instead proposed along with a distinct set of criteria adapted from the work of Goodman (Goodman, 1998a). Also outlined in this study is the author-created measure named the *Client Vignette Scoring Instrument* (CVSI), which is based on the proposed construct of "cybersex addiction." The internal reliability and construct validity of the CVSI, undertaken through a pilot study

[1] For the purposes of this study the construct of "cybersex addiction" is housed within the overarching construct of sex addition.

(Phase I of this project) conducted with both doctoral students in counselling psychology or clinical psychology and Expert Validators in the field, was also examined to ensure the usability of this measure for the subsequent research phase (Phase II of this project).

Secondarily, the relationship between ability to identify the presenting problem, sexual attitude, and personal and professional characteristics was examined. Here, the main question being asked in this study is, "Can psychologists identify cybersex addiction among clients?" In order to answer this question the following questions were explored:

1. Is cybersex addiction selected more often than other categories by psychologists in their identification of the presenting problem among clients?
2. (a) Is there a relationship between psychologists' age, their number of years of practice, their Internet familiarity, their cybersex addiction familiarity, and their sexual attitude, and their perception of the presenting problem of cybersex-addicted clients?

   (b) Is there a significant difference between age groups of psychologists on their perception of the presenting problem of cybersex-addicted clients?
3. Is there a significant difference in the sexual attitudes of psychologists on their perception of the presenting problem of cybersex-addicted clients?
4. Is there a significant difference between the genders of psychologists on their perception of the presenting problem of cybersex-addicted clients?
5. Is there a significant difference between the provinces of registration of psychologists on their perception of the presenting problem of cybersex-

addicted clients?

6. Is there a significant difference in the level of training of psychologists on their perception of the presenting problem of cybersex-addicted clients?

Currently practicing fully registered psychologists were recruited via the Canadian Psychological Association (CPA) and the Psychologists Association of Alberta (PAA) to participate in Phase II of this project and surveyed either online or via mail. Participants completed two independent measures and one dependent measure. The *Client Vignette Scoring Instrument* (CVSI) served as the dependent measure and assessed the ability of participants to identify and perceive the presenting problem in three fictional case vignettes. The *Modified Sexual Opinion Survey-Revised* (SOS-R-M) was used as an independent measure to assess the sexual attitudes and opinions of participants on a continuum of erotophilic (*sexually liberal*) to erotophobic (*sexually conservative*). Participants also completed a *personal and professional demographic survey*, which also served as an independent and descriptive measure. A table overview of the method for this study (Phases I and II) can be found in Appendix A.

Definitions

There is a lack of clarity among many researchers in the field of cybersex addiction about the meaning of several key terms. Below is a list of working definitions of some key terms used throughout this paper.

Addiction – "...a condition in which behaviour that can function to produce pleasure and to reduce painful affects is employed in a pattern that is characterized by two key features: (1) recurrent failure to control the behaviour,

and (2) continuation of the behaviour despite substantial harmful consequences" (Goodman, 2001, p. 195). Also includes the components of salience, mood modification, tolerance, withdrawal, conflict, and relapse (Griffiths, 2001).

Counsellor – Often used interchangeably with the term *therapist* (below), a counsellor is anyone who provides counselling. A counsellor may or may not be registered with a regulatory body, and the highest education level they have completed may range from high school to an undergraduate degree to a master's and/or doctoral degree. In this study this term will sometimes be used to refer generally to Registered Psychologists (see below).

Cybering (or online chat) – A form of OSA (see below) in which "... two or more people are engaging in sexual talk [via typed text], while online, for the purposes of sexual pleasure and may or may not include masturbation [by one or more parties]" (Daneback, Cooper, & Månsson, 2005, Abstract, p. 321).

Cybersex – "...the use of digitalized sexual content (visual, auditory, or written), obtained either over the Internet or as data retrieved by a computer, for the purposes or sexual arousal and stimulation..." (Schneider & Weiss, 2001, p. 7).

Cybersex Addiction (CSA) – a form of online sexual behaviour in a pattern that is characterized by two key features: (1) recurrent failure to control the online sexual behaviour, and (2) continuation of the online sexual behaviour despite substantial harmful consequences (Adapted from Goodman, 1998a). Also includes the components of salience, mood modification, tolerance, withdrawal, conflict, and relapse (Griffiths, 2001; Griffiths, 2004).

Diagnostic and Statistical Manual of Mental Disorders (DSM) – the standard classification of mental disorders used by mental health professionals in Canada and the United States, published by the American Psychiatric Association. This manual is currently in its fifth edition (referred to as DSM-5; APA, 2013), which was published in May, 2013[2]. The DSM is a tool to facilitate communication between mental health professionals and contains diagnostic codes that can be used to satisfy record keeping and reimbursement needs (APA, 2008).

Healthy sexuality – "...Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (World Health Organization [WHO], 2002)

Online Sexual Activities (OSA) – Using the Internet (including text, audio, graphic files) for any activity that involves sexuality for the purposes of entertainment, recreation, exploration, education, support, commerce, and/or finding sexual or romantic partners (Cooper & Griffin-Shelley, 2002).

[2] The fourth edition text revised version of the Diagnostic and Statistical manual of Mental Disorders (DSM-IV-TR; APA, 2000) was used in this study as it was the version of the manual current during that time.

Online Sexual Behaviour (OSB) – Sexual behaviour refers to "…verbal and non-verbal expressions of sexuality… including both genital and non-genital activities… can occur alone or with other people… refers… also to seduction and courtship… can be highly subjective" (Sharpe, 2003, pp. 420-421). Online (see "cybersex" above) it can involve, but is not limited to, viewing, downloading, printing and/or saving pornography (video, still images, audio), posting personal sex ads and then meeting in person for sexual activities, sexually explicit chat in chat rooms, "live sex" using webcams, viewing and/or trading sexual images via online newsgroups, writing and reading erotic stories, joining paid sexual membership communities, online strip clubs, playing X-rated video games online, viewing sexual CD-ROM content, and watching sexual movies via DVD on the computer (Carnes et al., 2001; Schneider & Weiss, 2001; Weiss & Schneider, 2006; Yassa, 2006; Yassa, 2008; Young, 2001).

Online Sexual Problems (OSP) – "...the full range of difficulties that people can have due to engaging in OSA... include[ing] negative financial, legal, occupational, relationship, and personal repercussions... The 'problem' may range from a single incident to a pattern of excessive involvement. The consequences may involve feelings of guilt, loss of a job or relationship, sexually transmitted diseases (STDs), etc." (Cooper & Griffin-Shelley, 2002, pp. 3-4).

Registered Psychologist – Refers to a mental health practitioner who is registered in a provincial (in Canada) or state (in the U.S.) licensing body. Highest level of education obtained varies by licensing body, but is no less than a master's degree. In Alberta, a minimum of a master's degree is required for

registration as a Psychologist, whereas in some other Canadian provinces it may be a doctoral degree. Registered Psychologists can come from Counselling or Clinical programs. The terms counsellor, therapist, or psychotherapist will be used interchangeably in this document to generally refer to practitioners in the mental health field and will include registered Psychologists.

Sex – can refer to gender (male, female, intersex) or sexual intercourse.

Sex Addiction (SA) – "...Some form of sexual behaviour in a pattern that [is] characterized by recurrent failure to control the behaviour and continuation of the behaviour despite significant harmful consequences" (Goodman, 1998a, p. 8). Also includes the components of salience, mood modification, tolerance, withdrawal, conflict, and relapse (Griffiths, 2001).

Sexuality – "...a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors" (WHO, 2002).

Therapist – See the term *counsellor* (above). This term will also sometimes be used in this study to refer generally to Registered Psychologists (see above).

Chapter 2 - Literature Review

Sexuality

The field of sexuality is vast and, to date, no one unifying theory exists regarding sexual development (Sharpe, 2003, Abstract, p. 420). Various frameworks, such as psychoanalytic theory (Baumeister, Maner, & DeWall, 2006; Goldman & Goldman, 1982; Hirsch, 1999; Levine, 2007; Masters, Johnson, & Kolodny, 1988; McRae, 1997; Seidman, 2007; Steele, 1996; Wiederman, 2003), learning theory (Hirsch, 1999; Masters et al., 1988; Storms, 1981; including social learning theory [Gagnon & Simon, 1973; Hirsch, 1999; Seligman, 1971; Storms, 1981]), cognitive-behavioural theory (Hirsch, 1999; Wiederman, 2003), constructionist theory (Bay-Cheng, 2006; James, 2007; Lewis, Neighbors, & Malheim, 2006; Maticka-Tyndale, 2001; Phillips & Reay, 2002; Seidman, 2007; The Social Construction of Sexuality, 2007; Tiefer, 2004; Wiederman, 2003; including script theory [Bay-Cheng, 2006; Gagnon & Simon, 1973; James, 2007; Laws & Shwartz, 1981; Leitenberg & Henning, 1995; LeVay & Valente, 2002; Lopez & George, 1995; Seidman, 2007; Storms, 1981; Surveying Sex, 2007]), and family systems theory (Berk, 1989; Hirsch, 1999; Maddock, 1983), have attempted to achieve this with various degrees of success.

For example, psychoanalytic theory heavily influenced theories of sexuality in the early 1900s and is based in the writings of Sigmund Freud, who regarded the sexual instinct as one of the primary underlying motivations of human striving (Baumeister et al., 2006) and at the centre of the self, resulting in conflict with society's norms and rules (Seidman, 2007). Psychoanalytic theory

posits that such a thing as “normal” sexual development exists (Seidman, 2007) and Freud presented the psychosexual stages (i.e., oral, anal, phallic, latency, and genital) as a means of conceptualizing it (Hirsch, 1999; Masters et al., 1988), however they remain untested, lack empirical evidence, and have been charged as being culturally insensitive, imprecise, inadequate, too narrow, deceptive, and male-centric (Bowlby, 1964; Goldman & Goldman, 1982; Hirsch, 1999; Rutter, 1971).

In contrast, learning theories, especially social learning theory, hold that learning is the main influencer of human sexual behaviour and occurs via the interaction of humans and their environment (or in the case of social learning theory, their social environment; Hirsch, 1999; Masters et al., 1988). Ivan Pavlov, a seminal figure of classical conditioning in which sexual arousal was argued to be the result of stimulus pairing (Hirsch, 1999; Masters et al., 1988), was followed by John B. Watson and proponents of operant conditioning (i.e., Edward Thorndike and B. F. Skinner) in which sexual behaviour was said to follow as the result of positive or negative consequences, with positive consequences increasing and negative ones decreasing the frequency of said sexual behaviour recurring (Hirsch, 1999; Masters et al., 1988). Albert Bandura, who introduced social learning theory, took the work of previous learning theorists and built upon it with the claim that people learn what sexual behaviours to express based on early responses to parental expectations and reinforcement (Hirsch, 1999; Mischel, 1967).

The cognitive-behavioural theory of sexuality is influenced by Jean

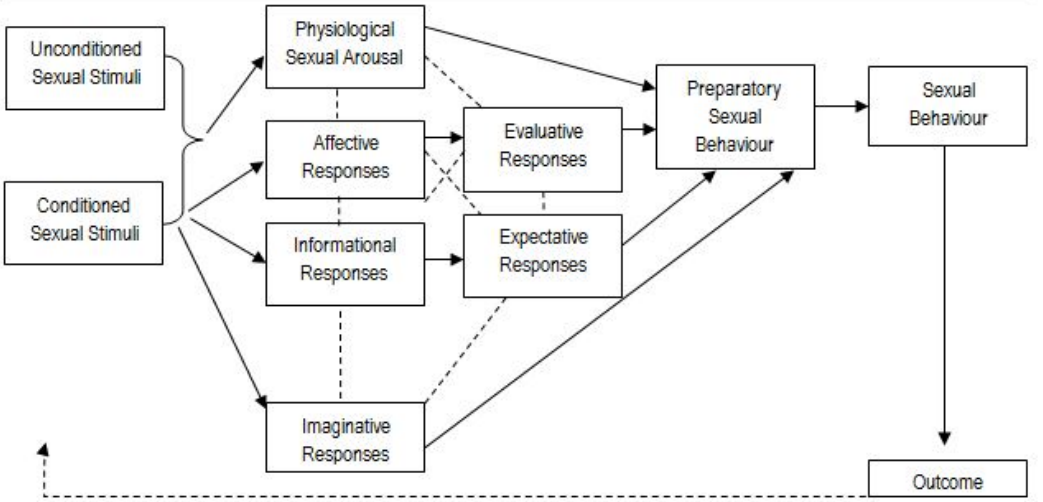
Piaget's four stages of development (i.e., sensorimotor, preoperational, concrete operational, and formal operational) and is based on the underlying belief that behaviour follows thought (Hirsch, 1999; Martinson, 1976). In cognitive-behavioural theory cognitive perspectives about ones' own sexuality are referred to as "sexual self-schemas" and they are derived from past experiences, result in ones existing sexual thoughts (which are either positive, negative, or neutral), and influence sexual behaviour (Cyranowski & Andersen, 1998) via operant and/or classical conditioning pathways (Wiederman, 2003).

Michel Foucault, who is a main figure in the social constructionism approach to sexuality (Bay-Cheng, 2006), argued that sex and sexuality is at the core of our existing society's control (Seidman, 2007), and that what is considered normal, taboo and pathological today is a direct outgrowth of that which serves social institutions, the modern state, and those in positions of power (Bay-Cheng, 2006; James, 2007; Lewis et al., 2006; Seidman, 2007; Wiederman, 2003). Script theory of sexuality holds that specific rules and expectancies about sexual behaviour are socially constructed and guide what we understand about sex and sexual behaviour, who we're meant to have it with, when and where we're meant to have it, and what doing it means (Bay-Cheng, 2006; Seidman, 2007). While the creation of sexual scripts falls under social constructionism, the implementation and acceptance of said scripts is socially learned and falls under social learning theory. Sexual fantasy, for example, is a reflection of and contains information about what is considered to be socially acceptable sexual roles and behaviour for men and women (Baumeister et al., 2006; Bay-Cheng, 2006;

Leitenberg & Henning, 1995; Lopez & George, 1995) and individual acceptance of and arousal in response to such fantasy is a result of the feedback we receive (positive or negative) from our relationships and internalize that either reinforces or diminishes sexual response (James, 2007). In sexual script theory the biological instinct informing sexual behaviour among humans does not exist (LeVay & Valente, 2002; Simon & Gagnon, 1986). Although these several theories have utility when attempting to understand human sexuality, the social-psychologically based theory known as the Sexual Behaviour Sequence has far greater utility for the purposes of this project.

The Sexual Behaviour Sequence (SBS; Byrne, 1977; Fisher, 1986; Fisher & Barak, 2001) is a social psychological model that attempts to describe our arousal, affective, cognitive and behavioural responses to conditioned and unconditioned sexual stimuli, as well as how the outcome of these responses reinforces approach or avoidance stances towards future sexual stimuli and behaviour. This model also serves as a comprehensive framework to explain how individuals can be drawn towards cybersex and the psychological and behavioural effect this exposure then has on their future cybersex-related behaviour (see Figure 1 below, adapted from Byrne, 1977; Fisher & Barak, 2001).

Figure 1: The Sexual Behaviour Sequence Model



With regards to arousal, the SBS states that unconditioned sexual stimuli lead to arousal via genital stimulation, visual cues and pheromone exposure (Byrne, 1977; Fisher, 1986). Once individuals experience arousal then preparatory sexual behaviour (e.g., closing the door and/or curtains, removing clothing, initiating sexual chat) is likely to occur (Fisher & Barak, 2001). Engaging in preparatory sexual behaviour increases the chances of actual sexual behaviour occurring. Once actual sexual behaviour has occurred, the individual will subjectively experience this as either positive or negative, which subsequently feeds back to condition future sexual arousal as either positive or negative, thereby influencing whether future sexual stimuli will progress through to future sexual behaviour (Fisher & Barak, 2001).

In addition to arousal, the SBS states that individuals will have affective and evaluative responses to sexual stimuli. Affective and evaluative responses to sexual content are shaped by an individual's history. The SBS states that if an

individual has had rewarding experiences regarding sex and sexuality they are likely to develop positive affect and evaluations regarding sex, otherwise termed erotophilia (Fisher, 1986; Fisher, White, et al., 1988). If, however, an individual has had negative or punishing experiences regarding sex and sexuality, then they are more likely to develop negative affect and evaluations regarding sex and sexuality, otherwise known as erotophobia (Fisher, 1986; Fisher, White, et al., 1988). Positive affective and evaluative responses to sexual stimuli are more likely to lead to preparatory sexual behaviour, which in turn is more likely to lead to actual sexual behaviour. This will most likely be experienced as positive (Fisher & Barak, 2001), and a positive response is likely to strengthen future positive affective and evaluative responses to sexual stimuli, thereby reinforcing the cycle. On the other hand, negative affective and evaluative responses to sexual stimuli are more likely to lead to the avoidance of preparatory sexual behaviour, which is most likely to lead to the absence of actual sexual behaviour (Byrne, 1982 as cited in Kelley, 1985, p. 391; Fisher & Barak, 2001). This is likely to strengthen future negative affective and evaluative responses to sexual stimuli thereby reinforcing the cycle (Fisher & Barak, 2001).

According to the SBS, cognitive responses, including informational, expectative, and imaginative responses, are also experienced in response to sexual stimuli, along with arousal, affective and evaluative responses (Byrne, 1977; Fisher & Barak, 2001). Informational responses are defined as beliefs regarding sexual behaviour and expectative responses that constitute perceived probability estimates regarding sexual behaviour outcomes (Fisher & Barak, 2001).

Imaginative responses consist of "…script-like representations of entire sexual episodes…" (Fisher & Barak, 2001, p. 319), which could be used to test out sexual behaviour that one may want to carry out in the future, or privately experience behaviour that one would never actually carry out. These three cognitive responses join together to influence an individual's subjective experience of sexual stimuli, either for the positive or negative (Fisher, 1986; Fisher & Barak, 2001).

In the case of cybersex, the SBS holds that exposure leads to conditioned arousal, affective and evaluative, informational, expectative, and imaginative responses (Fisher & Barak, 2001). These responses together determine whether, when and what sexual outcome will occur, which will then determine the likelihood of future cybersex exposure. Cybersex exposure, therefore, is a self-regulated happening and an individual's future responses to cybersex are often consistent with their pre-existing response tendencies (Fisher & Barak, 2001).

There are two aspects of the SBS that are important to the current study and warrant further discussion: affect and evaluations (henceforth referred to as sexual attitudes), and the cybersex addiction outcome that can occur for some as a result of the powerful positive reinforcing cycle in response to cybersex exposure.

Sexual Attitudes

As outlined in the Sexual Behaviour Sequence, the learned tendency to respond to sexual stimuli (or cues) along a negative-to-positive affective and evaluative continuum is called erotophobia-erotophilia (Fisher, White, et al., 1988). The concept of erotophobia-erotophilia is among the most widely used in

the sex research literature (Lopez & George, 1995). According to the Sexual Behaviour Sequence, those who display positive sexual attitudes (erotophilia) are more likely than those who display negative sexual attitudes (erotophobia) to accept versus reject, and approach versus avoid, internal (e.g., fantasy) or external (e.g., sexually-explicit online images) sexual stimuli (Byrne, 1982 as cited in Kelley, 1985; Fisher, White, et al., 1988). There are three kinds of cues that draw out erotophobic-erotophilic reactions; "open sexual display, variations of sexual behaviour, and homoeroticism" (Gilbert & Gamache, 1984, p. 307). Cross-cultural validity of the concept of erotophobia-erotophilia has been demonstrated in the literature (Bose, DasGupta, & Burman, 1978 as cited in Fisher, White, et al., 1988; Lau, 1979 as cited in Fisher, White, et al., 1988).

Erotophilia (positive sexual attitude) is generally presumed to be the norm for human sexual development given the rewarding results (e.g., pleasure) inherent in sexual behaviour (Fisher, White, et al., 1988). Erotophobia (negative sexual attitude) is presumed to be the general result of sex-related punishment (i.e., negative social learning experiences) (Fisher, White, et al., 1988).

When treating clients regarding sexual matters, therapists' assessments of clients' erotophobic-erotophilic tendencies may be beneficial in understanding their potential responses to sexual discussion and education and the effect this may have on the pace of therapy (Gilbert & Gamache, 1984). The Sexual Opinion Survey (SOS; Fisher, White, et al., 1988) and its revised version (SOS-R; Fisher, White, et al., 1988) is a questionnaire that was created to measure the construct of erotophobia-erotophilia and is widely used. Lower scores on the

SOS are indicative of an erotophobic tendency, while higher scores indicate a tendency towards erotophilia. It should be noted, however, that the majority of individuals are situated at intermediate points along the erotophobic-erotophilic continuum, and are best described as *relatively* negative or positive in their sexual attitudes (Fisher, White, et al., 1988).

Sexual attitudes to erotica. Erotophobic individuals report more infrequent exposure to erotica (Fisher, Byrne, & White, 1983; Fisher, White, et al., 1988). Compared to erotophobics, however, erotophilic individuals are more likely to be motivated to view erotica (Kelley, 1985), have more positive responses and arousal to erotica (Fisher, White, et al., 1988), choose to view erotic content for longer exposure times (Becker & Byrne, 1985; Fisher, White, et al., 1988), and report liking (Lopez & George, 1995) and being aroused more (Lopez & George, 1995) by erotic content.

It is also notable that erotophiles of both genders made fewer errors recalling content from erotic images (Becker & Byrne, 1985; Fisher, White, et al., 1988) and also needed more trials and made more errors in paired-associate learning task after viewing an erotic film (Kelley, 1985). This suggests two things: first, that the recall of sexual information/content by erotophilic individuals is stronger than that of erotophobics; and second, erotophilic individuals had greater difficulty attending to a more challenging task as compared to an easy one after viewing sexual content.

Finally, people tend to gauge material more positively the more they become familiar with it (Boies, Knudson, & Young, 2004). Individuals who don't

tend to feel very negative about sexual content evaluate it more positively the more they are exposed to it (Boies et al., 2004; Byrne & Osland, 2000). This suggests that those who are relatively erotophilic may be more susceptible to the lure of the "anything goes" content available on the Internet.

Correlations with sexual attitudes. Erotophiles engage more in sexual fantasy (Fisher, White, et al., 1988), have more positive evaluations of and tend to engage more in masturbation (Fisher, White, et al., 1988), and are more likely to anticipate sexual intercourse, carry protection, and use contraception (Fisher, White, et al., 1988) consistently (Anllo, 1995). Erotophiles are more likely to learn and retain sex-related information (Fisher, White, et al., 1988) and are more likely to teach others about sex (Fisher, Miller, Byrne, & White, 1980; Fisher, White, et al., 1988). Erotophilia is linked to higher rates and a broader variety of sexual behaviours (Bogaert & Rushton, 1989; Lewis et al., 2006; Wright & Reise, 1997) and is also associated with greater engagement in risky sexual behaviour, such as having more sexual partners and engaging in more casual sex (Lewis et al., 2006). Erotophilic individuals are more open-minded regarding sexual matters (Wright & Reise, 1997), show more positive emotion when communicating about sexual matters (Fisher et al., 1980; Lopez & George, 1995), and are more likely to engage in various socially-unapproved pleasure-seeking behaviours (Durant, Carey, & Schroder, 2002). Erotophiles are more likely to engage in sex-related health-care and to take steps to prevent catching STDs (Fisher, White, et al., 1988). Feminists are more likely to be erotophilic than non-feminists or egalitarians (Bay-Cheng & Zucker, 2007). On surveys about

sensitive or sexual behaviours, erotophiles are more likely to engage in item-refusal on surveys of sensitive and sexual behaviours when anonymity is not assured (Durant et al., 2002). Finally, erotophilic medical students had more sexual knowledge and indicated more willingness to work with populations with socially-unapproved sexual issues (Fisher, Grenier, et al., 1988; Fisher, White, et al., 1988).

On the other hand, erotophobes are more likely to be "…'turned off' by, or reject out of hand, the idea of group sex, going to a stripper club, nudist camps, or sexual experimentation" (Wright & Reise, 1997, p. 184). Erotophobic individuals tend to report having less numerous and explicit sexual fantasies (Fisher & Gray, 1988; Smith, Becker, Byrne, & Przbyla, 1993), avoid masturbation (Fisher, White, et al., 1988), and may underreport as well as engage less in sexual behaviours (Durant et al., 2002). Erotophobes tend to be more homophobic, more authoritarian, have more orthodox values, value traditional sex roles, and have a higher need for achievement and be more achievement oriented (Fisher, White, et al., 1988). Erotophobia is associated with more reports of parental strictness regarding sexual matters and with more sex-related guilt, anxieties, and self-consciousness (Fisher, White, et al., 1988). Erotophobes are less likely to plan for and use contraceptives (Fisher et al., 1983; Fisher, White, et al., 1988), and they have more difficulty with learning, talking to, or teaching others about sexual matters (Fisher et al., 1983; Fisher & Gray, 1988; Fisher, Grenier, et al., 1988; Fisher et al., 1980; Yarber & McCabe, 1981; Yarber & Whitehill, 1981). Interestingly, erotophobic individuals reported lower levels of

sexual arousal, yet experienced higher levels of physiological arousal (Soleymani, 1999). Erotophobic students in an undergraduate sexuality class performed less well than their erotophilic peers (Byrne & Fisher, 1983; Fisher, White, et al., 1988; Hogue & Atkinson, 1989), and erotophobic medical students had less sexual knowledge and were less willing to work with populations with socially-unapproved sexual issues (Fisher, Grenier, et al., 1988; Fisher, White, et al., 1988).

Erotophobia is positively correlated with sex guilt (Fisher, White, et al., 1988; Leitenberg & Henning, 1995) and, indeed, erotophobia and sex guilt are often considered similar concepts (Leitenberg & Henning, 1995). Sex guilt (Fisher, White, et al., 1988; Mosher, 1966, 1968) is described as the general anticipation of self-mediated punishment when standards of proper sexual conduct are violated or expected to be violated (Fisher, White, et al., 1988; Mosher & Cross, 1971). In contrast, erotophiles are relatively low in sex guilt (Fisher, White, et al., 1988).

Sexual attitude and gender. There appear to be gender correlates with the construct of erotophobia-erotophilia. For example, men are more erotophilic than women across cultures and student and nonstudent samples (Fisher et al., 1983; Fisher & Gray, 1988; Fisher, White, et al., 1988). Men also tend to have greater permissiveness about auto-sexual activity (Lopez & George, 1995; Oliver & Hyde, 1993). It is possible that this tendency appears in part because there are social norms that negatively evaluate a female being interested in sex and so female respondents to the SOS or SOS-R may under-report their actual sexual

behaviours, thereby creating an artificially lower score. Keeping this in mind, it is interesting that erotophobic women appear to be more likely to have numerous premarital sexual partners (Fisher, White, et al., 1988).

Erotophilic males tend to be lower on achievement aspirations, endurance, harm avoidance, nurturance, and order (Fisher, White, et al., 1988; Saunders, Fisher, Hewitt, & Clayton, 1985), while erotophobic males are more likely to have the above socially valuable traits (Fisher, White, et al., 1988). Male respondents who indicated no religious affiliation also tended to score higher on the SOS (indicating erotophilia) as compared to those males who indicated either Protestant or Catholic religious affiliation, as well as females who indicated no, Protestant, or Catholic religious affiliation (Fisher, White, et al., 1988).

Erotophilic women are more sexually interested, report engaging in more sexual activity and being more sexually satisfied, are more likely to behave sexually and auto-sexually during pregnancy and postpartum, and to breastfeed their babies (Fisher & Gray, 1988; Fisher, White, et al., 1988). Erotophilic men were also more likely to engage in sex when their partners were pregnant and during postpartum, and also to be present at the birth of their baby (Fisher & Gray, 1988; Fisher, White, et al., 1988). Erotophilic women are more likely to conduct breast self-examinations and to schedule regular appointments with their gynaecologist (Fisher, White, et al., 1988).

Sexual attitude, age and socioeconomic status. Age distinctions in erotophobia-erotophilia appear to also exist. Sexual attitudes are negatively correlated with age, meaning that younger individuals tend to have more positive

sexual attitudes (erotophilia) than older individuals (Fisher, White, et al., 1988). At this time, however, the degree to which this finding is an age or a cohort effect is uncertain (Fisher, White, et al., 1988). Erotophilic scores on the SOS are also more frequently represented among higher rather than lower socio-economic status respondents (Gilbert & Gamache, 1984).

Cybersex Addiction

What is cybersex? Cybersex refers to "any form of sexual expression which is accessed through the computer or the Internet" (Schneider & Weiss, 2001, p. 7). Cybersex can include viewing, downloading, printing and/or saving pornography (video, still images, audio), posting personal sex ads and then meeting in person for sexual activities, sexually explicit chat in chat rooms, "live sex" using webcams, viewing and/or trading sexual images via online newsgroups, writing and reading erotic stories, joining paid sexual membership communities, online strip clubs, playing X-rated video games online, viewing sexual CD-ROM content, and watching sexual movies via DVD on the computer (Carnes et al., 2001; Schneider & Weiss, 2001; Weiss & Schneider, 2006; Yassa, 2006, 2008; Young, 2001).

Many people have found cybersex difficult to avoid. Even among youth aged 10-17 years, 25% had had unwanted exposure to nude pictures or images of people engaged in sex via the Internet, 20% had received unwanted sexual solicitation over the Internet during a one-year period, and about 3% had received aggressive sexual solicitations (Brown, 2006; Finkelhor, Mitchell, & Wolak, 2000; Longo, Brown, & Price Orcutt, 2002). The online sex industry uses various

strategies to increase their exposure to various new or potential consumers, including email ads, page stealing, and mouse trapping/jacking (Young, 2001). Most people are familiar with email ads, often referred to as spam, in which mass volumes of emails that include sexual content are sent to users mailboxes in the hopes that they will respond by following the links. "Page stealing" refers to a tactic in which the sex industry buys up domain names (www.Whitehouse.com) with spellings or addresses similar to those in existence already (www.Whitehouse.gov) and uses them as dummy sites for their sexual content (Young, 2001). This method is a means by which the sex industry hopes to generate new business from accidental searches or mistyped web addresses. More insidious versions of this are misspelled takes on common searches conducted by children, such as "Cinderella," "boy scouts," "Disney," etc (Young, 2001). Finally, mouse trapping/jacking is when individuals who access sex sites (intentionally or unintentionally) are unable to exit the site without other sex sites popping open rendering the user trapped in a loop (Young, 2001). While server providers can be purchased which limit access to sexual content, and most web browsers today provide the option of blocking pop-up advertising, tactics such as page stealing work around more basic porn blocker software rendering them ineffective in these instances.

Pathological or adaptive? There are two main views in the literature regarding online sexuality. The first holds that Internet sexuality is pathological and leads to addiction and compulsivity (Cooper, Scherer, et al., 1999). The assertion is also made that the Internet, with its vast supply of sexual material

catering to any and every kind of sexual fantasy, operationalizes through immediate and intermittent online reinforcement what would otherwise be self-extinguishing sexual fantasies (Brown, 2006; Cooper, Scherer, et al., 1999; Durkin & Bryant, 1995; Schwartz & Southern, 2000). Most people have a variety of fantasies, many of which they would never consider acting on due to the illegality of the action or the level of risk to themselves and/or others. However, this perspective asserts that when people are exposed to online sexual content that illustrates, glamorizes or supports such fantasies, their fantasies are much more likely to be strengthened and enhanced, which for some people may lead to the development of sexual preferences they did not have before. This appears to be the leading model in the literature with the majority of researchers examining the negative aspects of this activity.

The second view of online sexuality in the literature is that Internet sexuality is adaptive and supports sexual expression, exploration and relatedness (Cooper, Scherer, et al., 1999). Advocates of this perspective hold that online sexuality can normalize sexual desires between couples, enhance relational sex, and inform discussions about sex and sexuality (Cooper, Scherer, et al., 1999). Approval, affirmation and access to sexuality for the disenfranchised or disabled user are also cited as among the benefits of cybersex (Cooper, Scherer, et al., 1999). Proponents of this view do acknowledge, however, that problems can be experienced for some people with online sexuality, but they suggest that those most likely to experience problems are loners, paraphilics and unhappy partners of online sexuality users (Cooper, Scherer, et al., 1999).

The reality is that the Internet itself is neither inherently good nor bad, and that online sexual behaviour exists on a continuum that ranges from adaptive to pathological.

What is cybersex addiction? Cybersex has been described as the crack cocaine of sexual addiction (Orzack & Ross, 2000) and it appears to be just as addictive. Cybersex addiction is not limited to any one race, gender, age group, or culture (Young, 2001). In order for cybersex to be considered an addiction, it must meet the basic requirements of any addiction, which include (1) an increased loss of control and compulsivity of the behaviour, (2) a continuation of the behaviour despite negative consequences in areas such as important relationships, employment, health, or the law, and (3) an obsessiveness and preoccupation around thinking about or being actively involved in the behaviour (Carnes et al., 2001; Weiss & Schneider, 2006). Some core components of cybersex addiction that have been cited are salience, mood-modification, tolerance, withdrawal symptoms, conflict, and relapse (Griffiths, 1996a; Griffiths, 1996b; Griffiths, 2001). Perhaps the best way to understand cybersex addiction is through a set of symptomatic criteria. Ten criteria that indicate the presence of problematic cybersexual behaviour (Carnes et al., 2001, pp. 31–37) are:

1. a preoccupation with sex on the Internet;
2. frequently engaging in sex on the Internet more often and/or for longer periods of time than intended;
3. repeated unsuccessful efforts to control, cut back or stop engaging in sex on the Internet;

4. restlessness or irritability when attempting to cut down or stop engaging in sex on the Internet;

5. using sex on the Internet as a way of escaping from problems, or of relieving such feelings as helplessness, guilt, anxiety, or depression;

6. returning to sex on the Internet day after day in search of a more intense or higher risk sexual experience;

7. lying to family members, therapists, or others to conceal involvement with sex on the Internet;

8. committing illegal sexual acts online (e.g., sending or downloading child pornography, and/or soliciting illegal sex acts online);

9. jeopardizing or losing a significant relationship, job, or educational/career opportunity because of online sexual behaviour; and

10. incurring significant financial consequences as a result of engaging in online sexual behaviour.

As indicated earlier, Goodman (1990, 2001) outlined a set of criteria which he held to indicate addiction in general (Goodman, 1990; see Appendix B) and sexual addiction in particular (Goodman, 1998a; see Appendix C). Diagnostic criteria for Cybersex Addiction (see Appendix D) was then derived from that for use in this study and reflects many of the ten criteria listed above.

The biopsychosocial model. While an in depth discussion of the biopsychosocial model of sex addiction (which, for our purposes, includes cybersex addiction) is beyond the scope of this literature review, the benefit of introducing the model is the greater understanding it brings to the illness and its

subsequent treatment. Using the biopsychosocial framework provides a more holistic conceptualization of the person, recognizes that sex addiction (including again, for our purposes, cybersex addiction) warrants acknowledgment and treatment, and challenges healthcare clinicians to formulate treatment plans that impact each of the biopsychosocial domains (Samenow, 2010b). It is important to note that the biopsychosocial model as presented here is intended to provide "...a better understanding of the predisposing, precipitating, perpetuating and protective factors..." (Samenow, 2010b, p. 70) of cybersex addiction, but not to imply causation (Samenow, 2010b).

The biological domain addressed in the biopsychosocial model deals with understanding the illness of sex/cybersex addiction via the structure and function of the brain (at a neurochemical and hormonal level), genetic expression and inheritance, physical and physiological disruption due to illness or disorder, and the brain's reaction to certain prescription and illicit substances (Samenow, 2010b). Research supporting the biological stance in understanding sex/cybersex addiction includes studies showing amygdala activation in males in response to sexual material (Hamman, Herman, & Nolan, 2004 as cited in Samenow, 2010b), higher dopamine and lowered serotonin levels linked to more sexual activity and reduced inhibition (Kafka, 2010), lowered testosterone connected to the reduced strength of sexual expression (Whaelen, 1976 as cited in Samenow, 2010b), and prefrontal cortex damage among sex addicts with a sexual trauma history (Ullman, 2007a, 2007b). Studies also show family histories of sex and other addictions among those with sex addictions (Carnes, 1991; Schneider &

Schneider, 1996) as well as variations in the expression of specific genes that impact sex drive (Ben Zion et al., 2006 as cited in Samenow, 2010b).

Many individuals and clinicians struggle to understand how cybersex could be addictive when no substance is being ingested. Similar to other addictive behaviours, such as gambling and risk-taking, cybersex can be a mood-altering experience leading to significant changes in brain neurochemistry (Schneider & Weiss, 2001; Weiss & Schneider, 2006). Neurochemicals such as adrenaline, serotonin, dopamine, and endorphins create a trance-like state for addicts, thus leading to changes in the body, intense physiological arousal and excitement, temporary relief from pain, escape, and soothing sensations (Katehakis, 2009). In this way addicts have "found a way to induce the chemical release within their own system, rather than an external source" (Schneider & Weiss, 2001, p. 27). It is notable that the object of cybersex addiction is not orgasm, but instead to maintain the trance-like euphoric state of hyper-arousal as long as possible (Schneider & Weiss, 2001; Weiss & Schneider, 2006). Once orgasm is achieved reality intrudes back in, bringing with it relationship problems, feelings of shame, and a strong desire to return to the cybersex-induced high, thereby perpetuating the addictive cycle.

From a neural perspective, it has been argued that the addictive cycle is maintained by an impaired prefrontal cortex (Katehakis, 2009; Ullman, 2007a, 2007b). Among sex/cybersex addicts, chronic high levels of stress (Katehakis, 2009), or trauma (sexual or otherwise) prior to complete neural myelination (around 15 years of age or later), result in disruptions to the brain's frontal lobe

neurochemical functioning and structure (Katehakis, 2009; Ullman, 2007a, 2007b). This disruption subsequently leads to impaired higher order executive functioning (which has been categorized as at the level of "brain damage") even though the addict retains an intact and normal IQ (Katehakis, 2009; Ullman, 2007a, 2007b). Among the many functions of the prefrontal cortex are the abilities to engage in goal-directed behaviour, plan, inhibit unwanted behaviours, self-monitor, and anticipate and grasp consequences. Research (Katehakis, 2009; Ullman, 2007a, 2007b;) has been proposed that it is this adaptive neural plasticity gone awry that results in the classic impairment in these abilities found among sex addicts.

The psychological domain references the behavioural, cognitive and psychodynamic schools of psychological thought. Within the psychological domain, the dual control model (Bancroft, 1999), attachment theory (Ainsworth, Blehar, Eaters, & Wall, 1978; Bowlby, 1973), trauma (Schwartz, Mark, & Galperin, 1995), cognitive and behavioural models (Carnes, 1991; Laws & Marshall, 1990) have the most empirical support (Samenow, 2010b). Research studies supporting the dual control model illustrate the connection between negative affect and increased sexual arousal and behaviour among sex addicts, unlike in the general population (Bancroft, 1999; Kafka, 2010; Bancroft & Vukadinovic, 2004). Attachment related studies among sex addicts have demonstrated a strong prevalence of insecure attachment style (Katehakis, 2009; Leedes, 1999; Zapf, Greiner, & Carroll, 2008) and a family-of-origin structure that was rigid and disengaged (Carnes, 1983; Opitz, Tsytsarev, & Froh, 2009;

Samenow, Yabiku, Ghulyan, Williams, & Swiggart, 2012; Katehakis, 2009). Studies also report a high prevalence of trauma history (including physical, sexual, emotional, psychological, and neglect) among sex addicts (Katehakis, 2009; Schwartz et al., 1995). Cognitive and behavioural studies highlight the role of the sex addicts' core beliefs (Carnes, 1983) and the classical and operant conditioning (Laws & Marshall, 1990) at work to maintain the addictive behaviour. Regarding cognitions, the core beliefs of the cybersex addict are four-fold. They include the beliefs that "I am basically a bad, unworthy person," "no one would love me as I am," "my needs are never going to be met if I have to depend on others," and "sex is my most important need" (Carnes, 1983, pp. 109 - 110; Carnes et al., 2001, pp. 43 - 45).

The social domain references the social, cultural and spiritual lens on sex/cybersex addiction. Support for the social domain includes studies that show a connection between poverty, unemployment and sexual drive and behaviours (Davis, 2009), the influence of premature youth sexualization via the media (Schwartz, 2008), the role of religious fundamentalism in predisposing some to sex-related psychological problems (Davies, 2003; Edger, 2012; Kwee, Dominguez, & Ferrell, 2007; Needell & Markowitz, 2004), and internalized homophobia among gay men as associated with sexually addictive behaviour (Dew & Chaney, 2005). Further studies speak to the role of the previously discussed anonymity, accessibility and affordability of the Internet (the Triple-A Engine; Cooper, 1997; Cooper et al., 2000; Weiss & Schneider, 2006) in relation

to sexually compulsive behaviour among those who may be at risk (Southern, 2008).

Previous findings. As indicated earlier, about 20% of Internet users engage in some form of cybersex (Cooper et al., 2000). According to one survey of 9,177 Internet users, 8% fit the category of "heavy users," spending between 11 to 80 or more hours per week engaged in online sexual pursuits, and fit the characteristics of sexually compulsive or addicted (Cooper, Putnam, et al., 1999; Cooper, Scherer, et al., 1999). In a follow-up study, only about 1% of these cybersex addicts/compulsives were shown to limit their sexually compulsive behaviour to the Internet, prompting the researchers to call it the purest sample of cybersex addicts identified to date (Cooper et al., 2000). This "pure" group of cybersex addicts was based on the respondents spending 11 plus hours per week in online sex *and* scoring significantly above average (2 *SD*s) on Kalichman's Sexual Compulsivity Scale (Cooper et al., 2000). It was proposed that this figure may be a significant underestimation, as potentially between 27-42% of the research sample were likely to have been in denial about the severity of their problems with online sexuality (Cooper et al., 2000).

The existence of denial as common among those with sexual acting out problems is also supported by the literature (Cooper et al., 2000). These addicts obsessively think about and plan access to cybersex. They may feel uncomfortable about their excessive or inappropriate use, try unsuccessfully to control it, and experience financial, employment and intimacy losses as a result (Schneider & Weiss, 2001). One study showed that, as a result of cybersex

addiction, roughly 68% of individuals reported having sexual problems in their relationship (Schneider, 2000b; Weiss & Schneider, 2006). This is not surprising when cybersex addicts can spend upwards of 15-25 hours per week engaged in cybersex (Cooper et al., 2000).

Sixty-five percent of participants surveyed who had high scores on the Sexual Addiction Screening Test (SAST) (Carnes, 1991) also indicated experiencing problems with cybersex (Delmonico & Carnes, 1999). In another survey, 92% of male cybersex addicts and 90% of female cybersex addicts self-identified as being sexual addicts (currently or formerly) (Schneider, 2000c). Seventy-one percent of sex addicts in one survey admitted to experiencing some kind of problem with cybersex (Carnes, 1999) and estimates exist that between 3 and 6% of the general population may be sex addicts (Carnes, 1991; Schneider, 1991). Other estimates put the percentage of sex addicts in America alone as high as 6-8% (Cooper, Putnam, et al., 1999).

Twenty-seven percent of men and 30% of women reported that they had experienced live online cybersex ("cybering") (Schneider, 2000c; Weiss & Schneider, 2006). One preliminary study indicated that 80% of women cybersex addicts sought off-line sexual connections as a result of their cybersex usage more often than male cybersex addicts (33.3%) (Schneider, 2000c; Weiss & Schneider, 2006). Women also make up roughly 25% of the members of sex and love addiction 12-step support groups (Weiss & Schneider, 2006). Findings suggest that generally male online sex users prefer more visually-oriented sexually explicit web sites, while female online sex users tend to prefer more relationship-

oriented sexual chat web sites (Cooper, Scherer, et al., 1999). One study found that as many as 40% of cybersex addicts had moved from having solely online sexual encounters to having (often unprotected) real-life sex (Schneider, 2000a ; Weiss & Schneider, 2006).

In a non-clinical sample of university students, cybersex was used for three primary reasons: establishing and keeping relationships, getting sex-related information, and sexual pleasure (Goodson, McCormick, & Evans, 2000). In another non-clinical sample of college students 73% reported accessing the Internet at least once a week, but of this group 13% reported that their excessive use had dramatically interfered with their personal functioning (Scherer, 1997). In an clinical sample of cybersex users in an outpatient psychiatry program, 90% of male patients and 52% of female patients reported some form of sexually addicted/compulsive behaviour, and 68% of both male and female patients had a history of sexual abuse (with females being more likely to present with such a history and PTSD) (Schwartz & Southern, 2000). Finally, research suggests that individuals who have low self-esteem, body distortion issues, untreated sexual dysfunction, and/or a pre-existing sexual addiction are more likely to develop cybersex addictions (Carnes, 1991; Griffiths, 2001).

The cycle of cybersex addiction. The cybersex addict goes through a four-step cycle that intensifies each time it is experienced (Carnes et al., 2001). Step one consists of Preoccupation, which refers to the dissociative state that the addict experiences in which their mind is consumed with obsessive thoughts of sex and the pursuit of sexual stimuli. Step two consists of Ritualization, which

refers to the cybersex addict's routines, unique to him or her, which often lead up to the sexual acting out behaviour and intensify the addictive experience through excitement and arousal (i.e., closing the curtains, locking the door, angling the computer screen, etc.). Step three involves Compulsive Sexual Behaviour, which refers to the addict's engagement in the actual end goal sexual behaviour. Addicts are unable to control or stop this acting out process. The final step, step four, is Despair, in which the addict comes back into awareness with feelings of hopelessness, failure and pain that once again the cycle has been re-enacted. These feelings of despair and pain are then difficult to tolerate and so the cycle is initiated again.

The four stages of cybersex addiction. With regards to the third step of The Addictive Cycle above (Compulsive Sexual Behaviour), four stages of addiction have been identified and they can be used to describe the progressive nature of cybersex addiction. They include addiction, escalation, desensitization, and acting out (Carnes et al., 2001). Addiction refers to the need to keep coming back for more cybersex, which has become the "drug of choice." Escalation refers to the need for more explicit, rougher and/or more deviant cybersex content to achieve the same effect. Desensitization refers to the tendency for cybersex content that was once shocking or taboo to become more acceptable over time the more one is exposed to it (Byrne & Osland, 2000; Lopez & George, 1995). Finally, acting out refers to the tendency for cybersex addicts to need to act out the sexual behaviours they have been exposed to online. While this last stage is not imminent for all cybersex addicts, it can pose a public and/or personal safety

issue when it occurs (Carnes et al., 2001).

Three types of cybersex users. There are three types of users of cybersex identified in the literature. The first group is labelled "Recreational" or "Casual" users and they find the sexual uses of the Internet fun and interesting (Weiss & Schneider, 2006, p. 29). When "Recreational Users" are involved in cybersex, they tend to use it for short periods of time and find it a playful distraction (Cooper, Putnam, et al., 1999, p.86). Over time, however, their interest in cybersex is not sustained due to its repetitive nature and their tendency is to become bored. This group is also referred to as "non-pathological users" (Cooper, Putnam, et al., 1999, p. 86). The majority of cybersex users fall into this group (Cooper, Putnam, et al., 1999).

The second group of cybersex users is called "At-risk Users" (Cooper, Putnam, et al., 1999, p. 88) or "Pleasure Seekers" (Weiss & Schneider, 2006, p. 29). This group is vulnerable to experiencing online sexual problems (OSPs) when under stress or due to underlying problems (Cooper, Putnam, et al., 1999). Periodically their use of cybersex is compulsive in nature but their tendency is to respond to the adverse consequences of their compulsive use (financial difficulties, conflict with a spouse regarding their overuse) by adjusting or stopping their cybersex use (Cooper, Putnam, et al., 1999). Characteristics of the group often include a previous personal history of behavioural addiction(s) or substance abuse, a tendency to take things personally, and trouble tolerating strong affect (Cooper, Putnam, et al., 1999; Weiss & Schneider, 2006). At-risk pleasure seekers also have a tendency to keep secrets, be self-focused, and use

sexual stimulation as a way of achieving distraction (Cooper, Putnam, et al., 1999; Weiss & Schneider, 2006). Two subtypes of this group have been identified; the Depressive Type and the Stress Reactive Type (Cooper, Putnam, et al., 1999).

The Depressive Type of At-risk User is generally dysthymic, anxious, and/or depressed, and Internet sex may be a powerful draw due to its ability to pierce their dysphoric state (Cooper, Putnam, et al., 1999). As a result of this, Depressive Types may be less likely to get bored with Internet sexual content, escalate their use over time, and use it more consistently. The Stress Reactive Type of At-risk Users includes those who are most likely to increase their use of online sexual content when they are highly stressed. Stress Reactive Types use online sex as a way of distracting themselves, coping with feelings that arise out of stress, or temporarily escaping (Cooper, Putnam, et al., 1999). Because of this, Stress Reactive Types may be more likely to self-reduce their cybersex usage after the stressful situation has ended and get back to their more typical daily coping strategies (Cooper, Putnam, et al., 1999).

The third group is termed “Sexually Addicted/Compulsive Users” and this group becomes hooked to cybersex usage regardless of the consequences (Cooper, Putnam, et al., 1999, p. 87; Weiss & Schneider, 2006, p. 30). The results are that they frequently report living a double life in their attempts to keep their usage a secret and do not have the ability to stop their compulsive cybersex usage on their own. Members of this group often have a history of abuse, trauma, neglect, a family and personal history of addictions, as well as co-morbid mood disorders such as anxiety or depression (Weiss & Schneider, 2006). Sexually

addicted users also have a history of intimacy problems and relationship issues and a tendency to leave relationships when the novelty has gone (Weiss & Schneider, 2006). Finally, this group tends to use pornography and masturbation in place of personal communication and support, be socially or emotionally isolated, and have the ability to live a double life (Weiss & Schneider, 2006).

The "Triple-A Engine" of cybersex. The "Triple-A Engine," which refers to Accessibility, Affordability and Anonymity, fuels the power and enticement of cybersex and contributes to its addictiveness (Weiss & Schneider, 2006, p. 13). Accessibility refers to both the ease of use of the Internet for most and the fact that it can be accessed almost anywhere, including work, coffee shops, Internet cafes, airports, libraries, schools, hotels, and cell phones. Accessibility also refers to the fact that the Internet is available 24/7, meaning no matter what time of day or night, the Internet is available for use.

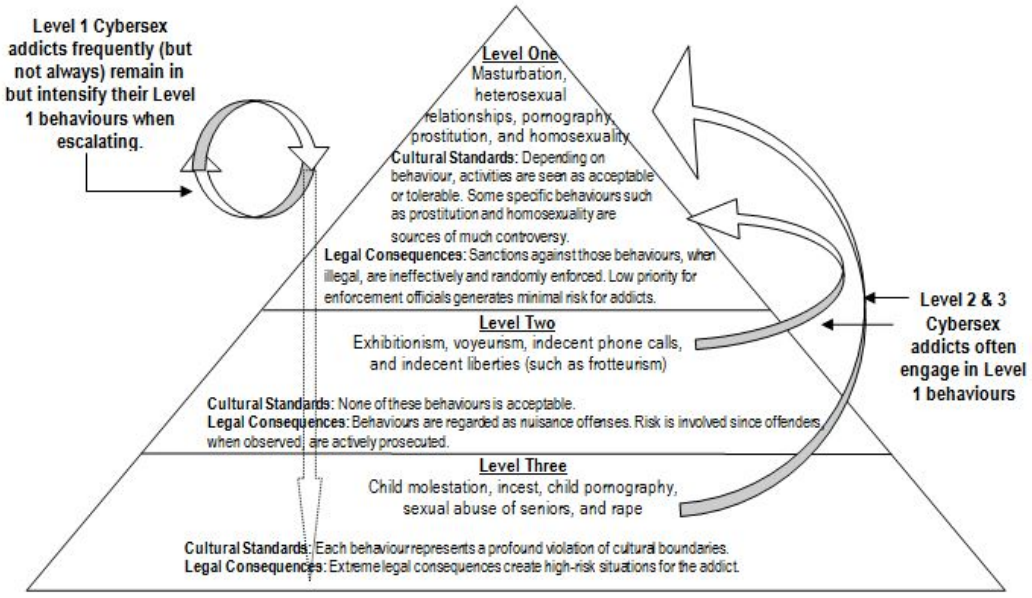
Affordability refers to the fact that an Internet connection from home can cost less than a dollar a day and almost everyone can access an Internet connection away from home for free, as illustrated by some of the examples in the previous paragraph. Additionally, the vast majority of the information available on the Internet is free of charge, one can access a lot of sexual content for free, and less than 1% of online sex users pay for their sexual content online (Branwyn, 1999 as cited in Cooper et al., 2001).

Anonymity refers to the perception of privacy created by the Internet, in which one can surf without leaving home and without being observed. In the case of cybersex, individuals who may never have gone to a pornographic theatre,

bookstore or strip club due to embarrassment or discomfort can now engage in all the same behaviours from the perceived privacy of their home, work computers, etc. This anonymity also means that users are not restricted to the attributes they have when using the Internet. For example, 48% of 9,000 Internet users surveyed admitted to changing their age "occasionally," and 23% admitted to doing so "often," while 38% admitted to changing their race, and 5% admitted to changing their gender (Cooper et al., 2000). This feature, in which one can play at being whomever one wants, makes cyberspace an attractive venue for users to explore assuming any identity they wish.

Levels of problematic sexual behaviour. Three levels of problem sexual behaviour have been distinguished (Carnes, 1983) and are illustrated in Figure 2. In Level One, the behaviours engaged in are generally acceptable although they have the potential to become addictive, such as masturbation, multiple partners, accessing prostitutes (in some parts of the world where it is not illegal), pornography and cybersex use. Level Two behaviours are outside of the realm of

*Figure 2: Levels of Problematic Sexual Behaviour (*Carnes, 1983*) and the Relationship to Cybersex Addiction*



socially accepted norms and include nuisance crimes such as voyeurism, public sex, exhibitionism, obscene phone calls, and frotteurism (rubbing up against an unsuspecting or unwilling person). Level Three behaviours, then, include more serious crimes and are considered social taboos, such as incest, child molestation, using child pornography, rape, and sexual abuse of seniors.

Depending on how cybersex is accessed and used it can be located in each of the three levels indicated here. When a behaviour becomes addictive the addict often needs more (increase in tolerance) and often stronger versions (escalation) of their drug of choice to achieve the same effects that was once experienced (Schneider & Weiss, 2001). In the case of cybersex addiction, although Level Two and Level Three cybersex addicts will often engage in Level One behaviours, Level One addicts will, when increasing tolerance and escalating, frequently remain in, but intensify, their Level One behaviours.

Telltale signs. Rarely do people with cybersex addiction present to therapy with this as their primary complaint. It is therefore useful for therapists, not to mention family members, to be able to identify which behaviours may be indicators of cybersex addiction. Some warning signs include: relationship problems as a result of Internet use, sexual anorexia (compulsive avoidance of sexuality in an attempt to compensate for uncontrolled sexual acting out), threat of or actual job loss, problems with the law, depression, loneliness and/or social isolation, substance abuse, other compulsive behaviours such as shopping, gambling, eating, and sleep disorders (Carnes et al., 2001).

Naming and categorization.

Addiction, compulsivity or impulsivity? There is much debate in the literature regarding whether sexual acting out (online or offline) constitutes an addiction, compulsion or impulsive behaviour. Proponents of the compulsive nature of sexual acting out hold that it should be termed "sexual compulsivity" and categorized in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as an Obsessive-Compulsive Disorder (OCD) (Goodman, 2001; Quadland, 1985; Weissberg & Levay, 1986; see Appendix E for a list of the diagnostic criteria of OCD). Compulsivity advocates argue that the function of the sexual acting out behaviour is to reduce the actor's experience of negative affect (e.g., anxiety and pain), thus allowing it to meet the definition of compulsions as defined by the DSM (Goodman, 2001).

Those who argue that this sexual condition should be conceptualized as an addiction (Goodman, 2001) agree with compulsivity advocates that sexual acting out behaviour serves, in part, the function of reducing anxiety or distress. They point to the fact that, while initially those who engage in sexual acting out may do so because it relieves negative affect, pleasure and gratification are also significant contributors (Goodman, 2001). Addiction advocates assert that this sexual acting out tends to be ego-syntonic in nature, meaning that the actor considers the behaviour to be consistent with his/her sense of self (Carnes et al., 2001; Goodman, 2001; Weiss & Schneider, 2006). Also pointed to as an argument against compulsivity categorization is the clarification made in the DSM-III-R (APA, 1987) that:

> [s]ome activities, such as... sexual behaviour... when engaged in excessively may be referred to as “compulsive”. However, the activities are not true compulsions because the person derives pleasure from the particular activity, and may wish to resist it only because of its secondary deleterious consequences (p. 246).

Therefore, the presence of pleasure, along with distress, indicates that sexual acting out behaviour does not truly fit the categorization of “sexual compulsivity.” Similarities have been drawn between drug addiction and sexual acting out in which the behaviour feels driven, results in harmful or unpleasant consequences, functions to reduce negative or painful affect, and also functions to produce enjoyment and gratification (Goodman, 2001).

Proponents of the impulsive nature of sexual acting out indicate that this sexual condition was classified in the DSM-III (APA, 1980) as an atypical impulse control disorder (Barth & Kinder, 1987; Goodman, 2001). Impulsivity advocates state that this sexual condition meets the DSM-IV-TR (APA, 2000) definition for impulse-control disorders (of which pathological gambling is one), which include the essential feature that the individual must experience a

> failure to resist the impulse, drive or temptation to perform an act that is harmful to the person or to others... an increasing sense of tension or arousal before committing the act... [and f]ollowing the act there may or may not be regret, self-reproach, or guilt (p. 663).

They state that sexual impulsivity should be included in the next DSM (DSM-5; APA, 2013) under Impulse-Control Disorders Not Elsewhere Classified. This, however, has not proven to be the case.

The argument by addiction advocates against the identification of sexual acting out behaviour as an impulse-control disorder is that claims to impulsivity seem to characterize substance dependence issues just as well (Goodman, 2001). Given that substance dependence is already acknowledged in the DSM as being an addictive disorder (although the term "addiction" appears nowhere in the DSM-IV-TR per se and only recently was included in the DSM-5[3]) and at the same time meets impulse-control disorder criteria, then it appears that classification of this sexual syndrome as an impulse-control disorder does not rule out its simultaneous classification as an addictive disorder (Goodman, 2001). It is notable that Gambling Disorder (previously "pathological gambling") has been recently relocated from the DSM-IV-TR (APA, 2000) section "Impulse-Control Disorders" to the section entitled "Substance-Related and Addictive Disorder" in the DSM-5 (APA, 2013) and labelled as a behavioural addiction.

Finally, addiction advocates point to the fact that sexual addiction was in the past listed in the DSM-III-R (APA, 1987) under the category "Sexual Disorder Not Otherwise Specified" as "nonparaphilic sexual addiction" (Goodman, 2001). It was, however, removed in subsequent editions due to claims that there were no scientific data available to support the idea that sexual behaviour could be conceptualized as an addiction (Goodman, 2001; Schmidt,

[3] under the section entitled "Substance-Related and Addictive Disorder."

1992). At the time, however, no definition was provided of addiction in the DSM (Goodman, 2001). A definition for Addictive Disorder was therefore added to the literature (Goodman, 2001) and can be found in its entirety in Appendix B. From these diagnostic criteria of Addictive Disorder, ones for Sexual Addiction were derived (Goodman, 2001; see Appendix C). The diagnostic criteria for Sexual Addiction contains both the claim put forth by compulsivity proponents that the primary function of sexual acting out is to reduce negative affect, and that put forth by impulsivity proponents that the primary function of sexual acting out is to produce pleasure or gratification (Goodman, 2001). The diagnostic criteria for cybersex addiction (CSA; see Appendix D) are adapted from the Sexual Addiction diagnostic criteria indicated here and will be used in this study.

Internet addiction or sex addiction? Griffiths (1999, 2000, 2001) argued that the Internet is simply a means by which people who already engage in excessive behaviours (e.g., gambling, shopping, poker, etc.) find another conduit for their compulsions. He is not alone, as the vast majority of the literature in the field supports the situating of cybersex addiction within the field of sex addiction research (Carnes et al., 2001; Cooper et al., 2000; Cooper & Griffin-Shelley, 2002; Delmonico, Griffin, & Carnes, 2002; Greenfield & Orzack, 2002; Griffiths, 2004; Orzack & Ross, 2000; Putnam & Maheu, 2000; Ross & Kuath, 2002; Schneider, 2000a, 2002; Schwartz & Southern, 2000; Weiss & Schneider, 2006). Young (2001), on the other hand, is a proponent of the view that cybersex addiction is a subtype of Internet addiction, not sex addiction. She stated that the addiction is based in actions that originate *inside* the computer and has more to do

with fantasy rather than real sex. Five subtypes of Internet addiction have been identified and they include cybersexual addiction, cyber-relationship addiction, Net compulsions, information overload, and computer addiction (Griffiths, 2001; Young, 1999). Cybersexual addiction refers to the compulsive visiting of online sex sites for access to cybersex and pornography (Griffiths, 2001). Cyber-relationship addiction refers to over-preoccupation in Internet-based relationships (Griffiths, 2001). Net compulsions involve preoccupations in thought and action around online shopping, gambling, stock-trading, etc. (Griffiths, 2001). Information overload refers to compulsive Internet searching or surfing, and computer addiction refers to obsessive online or computer game playing (Griffiths, 2001). Only the first two subtypes – cybersex addiction and cyber-relationship addiction – indicate addictions that are based potentially around sex (Griffiths, 2001).

The question of whether individuals with cybersex addiction are addicted to the sexual behaviour practiced over the Internet or to the Internet/computer as the conduit of sexual content is a difficult yet important one. Young (2001) supported her claim that cybersex is an Internet addiction by citing studies in which as high as 65% of cybersex addicts surveyed had no previous history of sexual addiction, and there are some case studies in which individuals reported being addicted to the Internet itself and engaging in a variety of Internet-based activities in a compulsive manner (Griffiths, 2001). Young (1996) modified the DSM-IV (APA, 1994) criteria for pathological gambling (an impulse-control disorder) for her study of Internet addiction over a 3-year time-frame and found

that Internet addicts in her sample were averaging 38 hours per week online for non-academic and nonprofessional activities. The non-addicts in her sample were found to be averaging only 8 hours per week online and they did not report any harmful consequences, as did the Internet-addicted group (Young, 1996). She added also that approximately 20% of Internet addicts were using some form of cybersex (Griffiths, 2001; Young, 1999). Despite all these claims there appears to be no empirical evidence to support the concept of cybersex addiction as an Internet rather than sex-based addiction (Griffiths, 2001). Because of this, cybersex addiction has been situated within the field of sex addiction for the purposes of this study and in the next section support for this decision is provided.

A note about hypersexual disorder. At the time this research study was being formulated (2008) and the data collected (2010), the diagnosis of Hypersexual Disorder (HD; Kafka, 2010) had not yet been formally proposed in the literature for use, let alone considered for inclusion in the DSM-5 (APA, 2013). To date, however, the constructs of sexual addiction and hypersexual disorder are still circulating through the literature as contenders for diagnostic nomenclature for this illness (Kor et al., 2013) as it relates to offline and online problematic sexual behaviours. It should be noted that hypersexual disorder was not subsequently included in the DSM-5 (APA, 2013) either as a diagnostic category, in Section III with those conditions that merit further research and attention, or in the appendix.

The term hypersexual disorder was proposed by Kafka (2010, 2013) with the intent to locate it on the spectrum of sexual desire, in which the pre-existing

DSM-IV-TR (APA, 2000) category of hyposexual disorder was located on the low end and hypersexual disorder would have been on the high end (Kafka, 2010; Samenow, 2010a). The label of hypersexual disorder also does not imply a specific etiology, as does that of sex addiction (Kafka, 2010, 2013; Kor et al., 2013; Samenow, 2010a, 2011). Hypersexual disorder has been defined as

> a persistent and pervasive pattern of behavior [sic] in which the individual loses control of their sexual fantasies, urges, or behaviors to a point that it causes the individual significant interpersonal distress and/or impairment. The criteria for the disorder specifies that the individual must spend excessive amounts of time seeking or engaging in sexual activity, is unable to stop sexual behavior, continues sexual behaviors despite negative consequences to self or others, and/or uses sex as a means to cope with anxiety, depression, or stressful life circumstances (APA, 2010 as cited in Samenow, 2011, p. 108).

Cybersex is included therein as a specifier of HD, and Appendix F outlines the proposed diagnostic criteria for hypersexual disorder (APA, 2010; Kafka, 2013) in detail.

The similarities between Kafka's (2010, 2013; APA, 2010) proposed HD diagnostic criteria and Goodman's (1998c) proposed SA diagnostic criteria (see Appendix C) adapted from the already existing substance dependence diagnostic criteria (DSM-IV-TR; APA, 2000) are striking. First, both Kafka (2010, 2013) and Goodman (1998c) appear to agree that the sexual behaviour in question must constitute a recurring act and not just a single or isolated event (as per the opening

descriptor in both HD and SA). Second, in the case of diagnostic criteria for both HD and SA, there appears to be an emphasis on the amount of time spent engaged in and/or planning to engage in the sexual behaviour, with the HD diagnostic criterion referring to “excessive time” (Criterion A1) and that of SA referring to “a great deal of time” (Criterion 5) and “over a longer period” (Criterion 3). Third, the diagnostic criteria proposed for both HD and SA both contain reference to the individuals repeated and failed attempts to reduce or control the problematic sexual behaviours (Criterion A4 in HD, and Criterion 4 in SA). Fourth, in both HD and SA there is reference in the diagnostic criteria to a tendency on the part of the individual to continue to engage in the problematic sexual behaviour in spite of negative consequences (Criterion A5 in HD, and Criterion 7 in SA). And finally, clinically significant impairment or distress in a variety of social, occupational and other areas is another diagnostic criteria that is included in both HD and SA (Criterion B in HD, and the opening descriptor and Criterion 6 in SA).

There are, however, some notable differences between the HD (Kafka, 2010, 2013) and SA (Goodman, 1998c) diagnostic models. First, the proposed diagnostic criteria for HD indicate the minimum time duration requirement of at least six months of engagement in the problematic sexual behaviour for the problem to be considered diagnosable. The proposed diagnostic criteria for SA indicate that the problematic sexual behaviour needs only to have occurred at any time in the same 12-month period for it to merit consideration of diagnosis. Second, while HD requires a minimum of four out of five behavioural criteria

(Criteria A) be endorsed for an individual to be diagnosed with HD, Goodman's (1998c) SA model requires the endorsement of only three out of seven behavioural criteria. Third, one of the exclusionary criteria for HD (Criterion D) requires a minimum age of 18 years before an individual can be diagnosed, while the diagnostic criteria for SA make no such restriction. Kafka (2013) explains that an age cut off of 18 years was added later on in the process in response to an outcry from public and professional communities that the absence of an age restriction may result in the pathologizing of "...every American adolescent male" (Kafka, 2013, p. 23). And finally, the proposed diagnostic criteria of Tolerance (Criteria 1a and 1b) and Withdrawal (Criteria 2a and 2b) that are present in Goodman's (1998c) SA diagnostic framework are not included in the proposed diagnostic criteria of HD. Rationale for the exclusion of withdrawal and tolerance includes the assertion that neurological and clinical research does not yet provide ample evidence to support their inclusion (Kafka, 2010, 2013; Kor et al., 2013; Samenow, 2010a, 2011).

Although there are several concerns that have arisen in response to the proposed diagnostic criteria for HD (Kor et al., 2013; Moser, 2013; Samenow, 2011), the construct itself is still in flux, and an in-depth exploration of these issues is beyond the intended parameters of this research when originally conceptualized. For the purposes of this study, it is notable that the formally cited reason for not including HD in the DSM-5 was due to an absence of ample supporting research (Carpenter & Krueger, 2013; Grohol, 2012; Kafka, 2013; Katehakis, 2012; Kor et al., 2013; Moser, 2013; Womack, Hook, Ramos, Davis,

& Penberthy, 2013).

Differential diagnosis. Common diagnoses often considered by therapists when presented with cybersex addiction symptoms include Obsessive-Compulsive Disorder (Goodman, 1998b, 2001; Stephens, n.d.), Major Depressive Disorder (Griffiths, 2004; Schwartz & Southern, 2000; Young & Rogers, 1998), Borderline Personality Disorder (Stephens, n.d.), Anti-social Personality Disorder (Schneider & Irons, 1998), Narcissistic Personality Disorder (Schneider & Irons, 1998), Impulse-Control Disorder (Goodman, 2001; Stephens, n.d.), Paraphilia (Schneider & Irons, 1998), Bipolar Affective Disorder I or II (Schneider & Irons, 1998), Post-traumatic Stress Disorder (Schneider & Irons, 1998), Adjustment Disorder (Schneider & Irons, 1998), Delusional Disorder (erotomanic type) (Schneider & Irons, 1998), and Dissociative Disorder (Schneider & Irons, 1998), among others. To be fair, some of these are also appropriate differential diagnoses that should be ruled out by the therapist when treating cybersex addicts. Too often, however, these differential diagnoses take the place of an accurate diagnosis of cybersex addiction. This is in part due to the therapist's lack of familiarity with this syndrome, his/her focus on secondary symptoms resulting from the addicts' experiences of negative consequences due to their acting out, or the current absence in the DSM-IV-TR (APA, 2000) of an appropriate diagnostic category. The result is that often clients do not get the correct diagnosis and the subsequent help they need with the real problem underlying their presentation to therapy.

Treatment. Treatment for cybersex addiction is centred, at least initially,

around breaking the addict's denial and isolation (Weiss & Schneider, 2006). The most effective treatment utilizes multiple modalities, including group approaches (either process psychotherapy groups or 12-step groups), individual therapy, and couples therapy (if warranted). Couples therapy, when the client is in a couple, should be used in tandem with, and not as a replacement for, group and individual therapy for both partners (Cooper, Scherer, et al., 1999). Those cybersex addicts who are entrenched in their online use, who suffer multiple relapses, or who pose a danger to themselves or to others can be and often are referred to inpatient treatment programs.

During the first three to six months of recovery both the addict and their partner in recovery can expect to experience relief, anger, increased hope, initially worsened then improved self-esteem, increased intimacy, grief, and spiritual growth (National Council on Sexual Addiction and Compulsivity, 2006; Yassa, 2006). In a recovering couple, sexual issues may surface as intimacy not intensity becomes the goal, and consequences of past choices are addressed (National Council on Sexual Addiction and Compulsivity, 2006).

Several approaches can be used to treat the recovering cybersex addict, with Cognitive-Behavioural Therapy (CBT) being among the most often recommended in the literature (Beck, 1995; Beck, Wright, Newman, & Liese, 1993; Carnes, 1994; Hagedorn & Juhnke, 2005; Katehakis, 2009; Myers, 1995; Orzack & Ross, 2000; Seligman & Hardenburg, 2000; Wolfe, 2000; Young, 2007) and, along with psychodynamic therapeutic approaches, used (Carnes, 1994; Seligman & Hardenburg, 2000). More recently, however, some evidence

has emerged that challenges the value of CBT in treating cybersex addicts due to limited impact on actual computer and Internet use (Orzack, Voluse, Wolf, & Hennen, 2006; Samenow, 2010b). More broadly, recommended components of treatment for cybersex addiction have included relapse prevention, review and reconstruction of one's arousal template and arousal reconditioning, enhancement of coping skills, strategies for building and maintaining intimacy, and treatment to address and minimize dissociative states (Southern, 2008).

Among the psychopharmaceutical options that have proven useful for treatment of sex/cybersex addiction are Selective Serotonin Reuptake Inhibitors (SSRIs; Kafka, 1994; Kafka & Prentky, 1992; Wainberg et al., 2006), SSRIs paired with other antidepressants (Kafka, 1994), SSRIs paired with psychostimulants (Kafka & Hennen, 2000), antidepressants and mood stabilizers alone (Coleman, Gratzer, Nesvacil, & Raymond, 2000; Kafka, 1991), and opiate antagonists (Raymond & Grant, 2010). Psychopharmaceutical treatment is often best paired with psychotherapeutic interventions, and indeed in many of the psychopharmaceutical-related studies indicated here it is unclear what effects may be attributed to concurrent psychotherapy (Nacify, Samenow, & Fong, 2013).

Challenges. As indicated earlier, denial is a core part of the addictive process and often is accompanied by shame (Adams & Robinson, 2001; Reed, 2000; Young, 1991) when cybersex addicted clients come in for treatment (Weiss, n.d.), which is rarely (Putnam & Maheu, 2000). The cybersex addict coming to therapy is often the result of pressure from another person or distress due to the secondary problems arising from their cybersex use, which they tend not to

identify as being connected to their acting out (Greenfield & Orzack, 2002). Cybersex addicted clients tend to minimize the effects of their cybersex behaviour on themselves and others, that is if they disclose them at all, which very few do (Schwartz & Southern, 2000). Types of denial common to cybersex addicts include entitlement, minimization, justification, blame of others, and rationalization (Weiss & Schneider, 2006). However, total self-disclosure is critical to the progression and successful outcome of therapy (Schwartz & Southern, 2000). It makes sense then that therapists need to rely on more than clients' self-reports in determining whether cybersex addiction is part of the presenting problem (Cooper et al., 2000) and recognize that disclosure may take a while as addicts tend to trust others slowly (Orzack & Ross, 2000).

Unfortunately, many cybersex addicts who finally made the leap to therapy found themselves with therapists who did not obtain an adequate sexual history and, as a result, completely missed identifying the cybersex addiction as the primary problem (Schneider, 2000a; Schneider, 2002). Cybersex addiction remains an area with which many mental health professionals are unfamiliar (Weiss & Schneider, 2006). To the unfortunate detriment of their cybersex-addicted clients, therapists may be unfamiliar with cybersex and cybersex addiction, or neglect to collect a sexual history because of personal characteristics.

Unwittingly, this may lead therapists to participate in and enable the client's denial (Smith, 2003; Swisher, 1995). As Smith (2003) states, "… therapist must be relatively free from neurosis, that is, free from the symptom of

duplicitous communication...” (p. 31). Therapists, however, are human and, like any of us, have their own belief systems, worldviews, and theoretical perspectives (Retzinger, 1998). In one study about sex addiction, 45% of counsellors indicated that the frequent undiagnosis or misdiagnosis of sex addiction in practice was due to counsellors’ unwillingness to deal with their own sexual issues or problems (Swisher, 1995). Shame is experienced universally, regardless of whether one is client or therapist (Hahn, 2000). A recent article in the American Psychological Association magazine, *The Monitor*, highlighted the tendency for clients to lie in therapy when dealing with shame-laden issues and indicated that therapists’ issues and characteristics appear to play a role in therapy in general and in why they are lied to (DeAngelis, 2008). Therapists’ familiarity and comfort with sexual issues (otherwise termed *positive sexual attitude* or *erotophilia*) influence the degree to which they are comfortable pursuing and talking about sexual issues in therapy (Schnarch, 1992, 1997).

Results from one early seminal study of 199 Marriage and Family Therapists (MFTs) showed that therapists’ assessments of sexual addiction may initially be affected by their values, gender, and level of religiosity (Hecker et al., 1995). Therapists were presented with four fictional client case vignettes designed to contain some symptom criteria for sex addiction, although not enough to endorse a diagnosis, which varied on the client's marital status, gender, and number of sex partners, but held the client's age constant at 28 years (Hecker et al., 1995). The study focused only on offline sexual behaviour with real partners and did not involve cyber or online activity. Results showed that therapists

tended to pathologize single clients with multiple partners more and labelled them more likely to be sexually addicted than married monogamous clients, regardless of the client's gender (Hecker et al., 1995). Results also indicated that therapists surveyed thought that single clients with multiple partners would need more therapy and longer-term treatment than married monogamous clients, regardless of the client's gender, and that single male clients with multiple partners would have the worst treatment outcome (Hecker et al., 1995). Furthermore, as compared to female therapists, male therapists tended to label all clients in the vignettes as more likely to have sex addiction, need longer-term treatment, and have worse treatment outcomes (Hecker et al., 1995). Finally, as compared to therapists with low religiosity, therapists with high religiosity were more likely to diagnose all clients in the vignettes as having sex addiction, and this was especially so among male therapists of high religiosity (Hecker et al., 1995).

In addition, results of a more recent and seminal study published by Ayres and Haddock (2009) after data collection had begun for this study highlighted the growing relevance of the research being conducted herein and examined the responses of 99 MFTs to a fictional case vignette of a heterosexual married male client presenting due to their problematic online pornography for couples therapy. The majority of therapists surveyed in their study had little to no graduate training on treating pornography issues (77.9%), and most (79.3%) felt inadequately or only minimally prepared to treat it (Ayres & Haddock, 2009). Responses by therapists to fictional case vignettes were collected, as well as measures of attitudes towards pornography, and revealed that those therapists with negative

attitudes towards pornography were more likely to assess for sex addiction as part of a series of protocols identified in the literature (Ayres & Haddock, 2009). Attitude towards pornography proved to be the only variable with any predictive strength for therapists assessing for sex addiction (among other protocols), even when combined in a model with therapists' level of training, familiarity with the literature on problematic pornography use, and orientation to feminist therapy (Ayres & Haddock, 2009). Furthermore, therapists who indicated a positive attitude towards pornography were found to be less likely to conduct an assessment of sex addiction (among other protocols), less likely to view the pornography use disclosed by the client as problematic, and more likely to hold the clients' partner responsible for the client's use of pornography (Ayres & Haddock, 2009).

It can, and has been, said that “therapy is not a value-free enterprise” (Hecker et al., 1995, p. 261; see also Beutler & Bergan, 1991; Strupp, 1980). As such, it makes sense to examine whether therapists can tell when the presenting problem is indeed cybersex addiction and what, if any, personal or professional attributes (including sexual attitudes) may be related to this ability.

Putting It All Together

As was indicated earlier, erotophobic individuals tend to perceive sexual material and behaviour from a more negative affective and evaluative stance, often based in more conservative and orthodox values. Additionally, erotophilic individuals’ recollections of sexual information and content is stronger than that of erotophobes (Fisher, White, et al., 1988), and erotophiles appear to have

greater trouble performing a more difficult task as compared to an easy one after viewing sexual content (Kelley, 1985). It has also been shown that erotophobes and erotophiles differ in the level of analysis they use for reviewing, retaining and retrieving sexual information (Hogue & Atkinson, 1989). Individuals tend to use fine-grained levels of analysis when they want to increase their information intake about a subject and a more global level of analysis when they are uninterested in the material being presented or want to avoid it (Hogue & Atkinson, 1989). Using a fine-grained level of analysis increases the retention and retrieval of details about what one is reviewing, whereas using a global level of analysis allows the reviewer to avoid the details. When presented with information about birth control, erotophiles were more likely to use a fine-grained level of analysis, while erotophobes were more likely to use a global level of analysis. In response to a conservative social values lecture, the level of analysis used by both erotophiles and erotophobes was almost identical (Hogue & Atkinson, 1989). It appears that erotophobic individuals do not want to focus on the details in sexual content.

Since we have also seen that medical practitioners are not exempt from being influenced by their sexual attitudes in carrying out of their professional duties (Fisher, Grenier, et al., 1988; Fisher, White, et al., 1988), it stands to reason that therapists in general and registered psychologists in particular, are no different. Add to this that clients presenting with cybersex addiction symptoms report that frequently therapists misdiagnose or minimize the symptoms and it becomes critical to examine how, if at all, therapists' attributes (including sexual

attitudes) may play a role in their perceptions of the presenting problems of their cybersex addicted clients.

On the basis of these facts, we are left with several questions. Will erotophobic psychologists be less likely to tell when the client's presenting problem is cybersex addiction because they are less likely to attend to sexual information from clients? Or, will erotophilic psychologists be more likely to tell when the client's presenting problem is cybersex addiction because they are more likely to attend to sexual information from clients? Will erotophobic psychologists be more likely to tell when the client's presenting problem is cybersex addiction because they are more likely to negatively judge the sexual behaviour of others? Or, will erotophilic psychologists be less likely to tell when the client's presenting problem is cybersex addiction because they are likely to be more permissive and accepting regarding the sexual behaviours of others? Although this study will not directly address what underlies psychologists' perceptions of cybersex addicted clients' presenting problems, it will permit us to begin examining the role of therapists and their attributes, including sexual attitudes, in the accuracy of their perception of the presenting problem of cybersex addicted clients.

Chapter 3 – Phase I: Creation and Pilot of the Client Vignette Scoring Instrument (CVSI)

The Client Vignette Scoring Instrument (CVSI)

The purpose of the CVSI. The main research question being studied herein is whether psychologists can accurately identify the presence of cybersex addiction among clients. In order to answer this question, and given the ethical issues, time and financial constraints of presenting participant psychologists with real or videotaped clients, the Client Vignette Scoring Instrument (CVSI) was created. The first version of the CVSI (CVSI-V1; see Appendix G for online version used) was then pilot tested on Ph.D. level graduate students in counselling and clinical psychology programs to ascertain internal reliability and construct validity for use in the subsequent main focus of this research.

The need for the CVSI. Although vignettes have been used in some earlier related (Ayers & Haddock, 2009; Hecker et al., 1995; Schover, 1981) and unrelated (Colby, Swanton, & Colby, 2012; Farrell & Lewis, 1990; Jung, Jamieson, Buro, & DeCesare, 2012) studies involving measuring respondent reaction and feedback, they do not meet the needs of this study requiring rigorously constructed symptom criteria for sex or cybersex addiction, either with or without other diagnostic criteria. As a result, in such studies it is hard to know to what extent participants' responses reflect the exact stimuli inserted into the vignette. Research on pre-existing measures involving specifically cybersex related case vignettes for use in this research revealed none at all, let alone any that included a built-in protocol for diagnostic criteria inclusion. Given that such

case vignettes were a necessary tool for answering the research questions posed by this study, a need was identified and, in response to this need, the CVSI was created[4].

Client Vignette Scoring Instrument - Version 1 (CVSI-V1)

Structure.

Cases. The CVSI-V1 (see non-online version in Appendix H) is composed of three fictional case vignettes (Sophie, Bill, and Jeff in order from case 1 to 3 respectively), adapted with permission from Goodman (1998b), followed by two questions each and measures both participants' identifications and perceptions of the presenting problem in each of the vignettes. Each vignette presents the case details of an individual experiencing symptoms related to Cybersex Addiction (CSA), Major Depressive Disorder (MDD) and Obsessive Compulsive Disorder (OCD). Appendix C provides the diagnostic criteria for Sex Addiction (SA), from which the diagnostic criteria for CSA had been adapted. Appendices D, I, and E provide the diagnostic criteria for CSA, MDD, and OCD respectively. Appendices J, K, and L outline which symptom/diagnostic criteria from CSA, MDD, and OCD, respectively, were presented in each case vignette of versions 1, 2 and 3 of the CVSI and with which question items they corresponded.

CSA criteria. As the table in Appendix J illustrates, in the CVSI-V1, cases 1 (Sophie) and 2 (Bill) were written to provide enough criteria for the identification of the presence of CSA, by meeting at least three criteria as adapted

[4] It should be noted that the CVSI was designed for use specifically in this study and at this time is not being proposed as a measure for use in other studies without further pilot testing on a larger sample to derive test-retest reliability and external validity.

from Goodman's (1998c; see also Orzack & Ross, 2000) criteria for Sex Addiction (SA; Appendix C). Case 3 (Jeff), however, was written to not provide enough criteria to indicate the presence of CSA. In that sense the case of Jeff contained no signal (i.e., low) for the presence of cybersex addiction, while the case of Sophie contained the minimum signal and the case of Bill contained the maximum signal (i.e., high) for the presence of cybersex addiction. Appendix M shows how the various components that make up each case of the CVSI-V1 correspond to the various diagnostic criteria for CSA (see Appendices N and O for the CVSI-V2 and CVSI-V3, respectively). The cases were organized in the above-indicated order (Sophie/Jeff/Bill) with an eye towards attempting to not bias participants against or towards the presence of cybersex addiction. Again, Appendix J can be referenced to show which CVSI-V1 question items correspond to which symptom criteria of CSA.

MDD criteria. All three cases of the CVSI-V1 were written to provide enough criteria for the diagnosis of MDD based on the symptoms found in the DSM-IV-TR[5] (APA, 2000; Appendix K). Included were those criteria that needed to be endorsed as present in order for the diagnosis to be met. Efforts were made to avoid inadvertent suggestion of those criteria that needed to be absent in order for the diagnosis to be met.

In order for a diagnosis of MDD to be made, the DSM-IV-TR (APA, 2000) advises that five or more of the symptoms indicated must have been present

[5] The DSM-IV-TR (APA, 2000) was the most current version of the manual available during the construction and implementation of the CVSI-V1, CVSI-V2 and CVSI-V3.

during the same 2-week period, representing a change from previous functioning, and at least one of the symptoms needs to be either depressed mood (criterion 1) or loss of interest or pleasure (criterion 2). In all three cases of the CVSI-V1 clinically significant distress or impairment in social, occupational, or other important areas of functioning (MDD criterion C) were implicated. Appendix M shows how the various components that make up each case of the CVSI-V1 correspond to the various diagnostic criteria for MDD (see Appendices N and O for the CVSI-V2 and CVSI-V3, respectively). Appendix K can be referenced to show which CVSI-V1 question items correspond to which symptom criteria of MDD.

OCD criteria. In the CVSI-V1, symptoms are also provided from OCD as outlined in the DSM-IV-TR (APA, 2000; Appendix E), however, while in cases 1 (Sophie) and 2 (Bill) there were enough criteria indicated to diagnose its presence, in case 3 (Jeff) there are not enough criteria indicated to diagnose OCD. In order for a diagnosis of OCD to be made, the DSM-IV-TR (APA, 2000) advises that all four criteria for obsessions or both criteria for compulsions need to be met, along with an awareness on the part of the individual at some point during the course of the disorder that their obsessions/compulsions are excessive or unreasonable (OCD criterion B). In all three cases of the CVSI-V1, marked distress, time consumption of more than 1 hour per day, significant interference with normal routine, occupational functioning or usual social activities or relationships (OCD criterion C) is also implicated. Appendix M shows how the various components that make up each case of the CVSI-V1 correspond to the various diagnostic

criteria for OCD (see Appendices N and O for the CVSI-V2 and CVSI-V3, respectively). Appendix L can be referenced to show which CVSI-V1 question items correspond to which symptom criteria of OCD.

***CVSI-V1 Question 1 - Perception of the presenting problem*.** In the CVSI-V1 Question 1, which immediately follows each of the three cases, participants were presented with a list of each of the criteria for CSA, MDD and OCD in staggered order and asked to indicate the degree to which they believed that each of the symptoms listed contributed to the presenting problem in each of the cases they read using a Likert rating scale that ranged from 0 (*not at all contributing*) to 4 (*a key contributor*). This question was designed to primarily measure the degree to which the participants accurately perceived the CSA symptoms that were built into each case. Secondarily, participants' perceptions of the MDD and OCD symptoms built into each case were measured.

Under Question 1, after each case vignette on the CVSI-V1, Items 1, 4, 7, 10, 13, 16, 19, 22, and 25 were specifically related to CSA criteria; Items 2, 5, 8, 11, 14, 17, 20, 23, 26, and 27 were specifically related to MDD criteria; and, Items 3, 6, 9, 12, 15, 18, 21, and 24 were specifically related to OCD criteria (see Appendix P). Each potential diagnosis, however, has a differing minimum number of criteria that must be endorsed before the diagnosis is considered met. For CSA, that minimum number is three (see Appendix D). For MDD with either depressed mood and/or markedly diminished interest or pleasure, the minimum number of symptom criteria that must be endorsed is six (five criteria plus one qualifier; see Appendix I). For OCD with obsessions the minimum number of

symptom criteria required for diagnosis to be met is six (four criteria plus two qualifiers) or for OCD with compulsions the minimum number is four (two criteria plus two qualifiers; see Appendix E). In the CVSI-V1 this meant that while the CSA and MDD were each composed of one scoring subscale comprised of adding various symptom criteria and qualifiers as per the unique scoring protocol for each, OCD was represented by two separate scoring sub-scales, one specific to OCD-obsessions and the other to OCD-compulsions. Scoring protocols for each of the CVSI-V1 subscales - CSA, MDD, OCD with Obsessions, and OCD with Compulsions - can be found in Appendix H.

The scoring protocol for all of the CVSI-V1 subscales involved maintaining the same coding as used for the Likert scale in the measure (0 - 4) and follows a basic additive approach with some specific modifications. Where the diagnostic criteria wording specifies the selection of either one criterion or another, then the scoring protocol reflects the inclusion of the highest score between the two criterion for each of the specific diagnoses (i.e., CSA, MDD, OCD-Obsessions, or OCD-Compulsions) so as not to artificially inflate the overall subscale score. Where the diagnostic criteria wording specifies that a specific criterion must be present as necessary for endorsement of a certain diagnoses (i.e., CSA, MDD, OCD-Obsessions, or OCD-Compulsions), then the scoring protocol reflects a score of less than a Likert of 3 (which is the minimum Likert rating required to indicate respondent endorsement) on that specific criterion with an overall subscale score of 0.

The resulting overall score for the CSA Subscale ranges on a continuum

from 0 - 28 and scores greater than or equal to 9 indicate a participant's endorsement of the construct Cybersex Addiction. In the case of Jeff, a score of 6 accurately reflects the number of CSA criteria that were actually built into the case (i.e., two CSA criteria at a minimum Likert rating of 3), in the case of Sophie that score is 12 (i.e., four CSA criteria at a minimum Likert rating of 3), and in the case of Bill that score is 21 (i.e., seven CSA criteria at a minimum Likert rating of 3). The resulting overall score for the MDD Subscale ranges on a continuum from 0 - 40 and scores greater than or equal to 18 indicate a participant's endorsement of the construct Major Depressive Disorder. In the case of Jeff, a score of 18 accurately reflects the number of CSA criteria that were actually built into the case (i.e., six MDD criteria at a minimum Likert rating of 3), in the case of Sophie that score is 15 (i.e., five MDD criteria at a minimum Likert rating of 3), and in the case of Bill that score is 15 (i.e., five MDD criteria at a minimum Likert rating of 3). The resulting overall score for the OCD-Obsessions Subscale ranges on a continuum from 0 - 24 and scores greater than or equal to 18 indicate a participant's endorsement of the construct Obsessive Compulsive Disorder with Obsessions. In the case of Jeff, a score of 9 accurately reflects the number of OCD-Obsessions criteria that were actually built into the case (i.e., three OCD-Obsessions criteria at a minimum Likert rating of 3), in the case of Sophie that score is 6 (i.e., two OCD-Obsessions criteria at a minimum Likert rating of 3), and in the case of Bill that score is 12 (i.e., four OCD-Obsessions criteria at a minimum Likert rating of 3). The resulting overall score for the OCD-Compulsions Subscale ranges on a continuum from 0 - 16 and scores greater than

or equal to 12 indicate a participant's endorsement of the construct Obsessive Compulsive Disorder with Compulsions. In the case of Jeff, a score of 0 accurately reflects the number of OCD-Compulsions criteria that were actually built into the case (i.e., 0 OCD-Compulsions criteria at a minimum Likert rating of 3), in the case of Sophie that score is 12 (i.e., four OCD-Compulsions criteria at a minimum Likert rating of 3), and in the case of Bill that score is 9 (i.e., three OCD-Compulsions criteria at a minimum Likert rating of 3).

CVSI-V1 Question 2 - Identification of the presenting problem. In Question 2 of the CVSI-V1, which immediately follows Question 1 after each of the three cases, participants were asked to select and rank the top five presenting problems that they believe were indicated in each of the cases they have read from a provided list of 29 options (see Appendix H). This question is essentially examining whether participants could identify the presence or absence of the label of CSA as the primary presenting problem as built into each case, rather than perceive the individual built in symptom criteria as in CVSI-V1 Question 1. The provided list in part included those for which CSA and SA have been most often mistaken (Schneider & Irons, 1998). Participants were presented with 29 options in the list in part to mask the presence of the Cybersex Addiction and Sex Addiction options and to avoid priming participants given the sexual content in the cases. Of the two categories of interest (CSA and SA), "Cybersex Addiction" (CSA) was of primary interest as it is the most technically accurate category that directly addresses the identified research question of whether participants can accurately identify its presence. The second category of interest, "Sex Addiction"

(SA), captures the more clinically accurate answer to the stated research question, because in actual clinical practice psychologists may use the broader label of sex addiction to encapsulate and convey the mental health problem of cybersex addiction, which, as has been argued earlier, would not clinically be wrong. To that end participants' tendency to identify CSA alone as well as CSA in combination with SA were examined.

Phase I: The Pilot

Method.

Participants.

Graduate students. Ph.D. students in Counselling or Clinical Psychology programs were recruited from the University of Alberta, the University of Calgary, and via the Canadian Psychological Association (CPA) Student Section. As stated earlier, the master's is the minimum entry level for registration as a psychologist among the various provinces of Canada, and most Ph.D. students in Canada would likely have at a minimum completed education at a master's level for admission into a Ph.D. in a psychology program. As such, this made Ph.D. students in Counselling or Clinical Psychology programs a good sample on which to pilot the CVSI-V1 in preparation for its use in Phase II of this study with registered psychologists.

Experts in sex/cybersex addiction. Finding experts in the field of cybersex or sex addiction proved difficult, as it was challenging to determine what constituted expertise in this area. It was decided that expertise would be defined for the purposes of this study as a combination of specific training in sex or

cybersex addiction and/or involvement in research specifically in the field of sex or cybersex addiction. Efforts were undertaken to locate potential experts with certification such as that of Certified Sex Addiction Therapist (CSAT) granted by the International Institute of Trauma and Addiction Professionals (IITAP), which meant the person had undergone specific certified training in the field. In addition, practical experience in seeing and treating a significant number of clients for sex/cybersex addiction was also considered and taken into account. Finally, it was preferred that the experts were registered or licensed psychologists but they did not have to be practicing in Canada. The proposed goal was to have two Expert Validators for the pilot of the CVSI-V1, and in the end three experts in sex/cybersex addiction participated; two were based in the United States and one in Alberta, Canada.

The first Expert Validator (EV1) was a male, Ph.D. level licensed psychologist and Certified Sex Addiction Therapist (CSAT) with IITAP, based in Michigan, USA, and held extensive research, publication and clinical experience in the field of sex and cybersex addiction. EV1 completed only the quantitative aspects of the CVSI-V1 and provided little to no feedback on the construction of the measure itself as requested.

The second Expert Validator (EV2) was a male, Ph.D. level licensed clinical social worker who was a practicing psychotherapist based in California, USA, and held extensive research, publication and clinical experience in the field of sex and cybersex addiction. EV2 appeared to misunderstand the instructions provided and did not complete the CVSI-V1 at all, opting instead to only provide

qualitative feedback about the measure's construction. As a result of this and the need for complete feedback (both quantitative, in the form of completion of the CVSI-V1, and qualitative in the form of comments and feedback on the measure's structure, format and question item wording) one more Expert Validator (EV3) was sought out beyond what was initially proposed.

In response to the feedback provided by EV1 and EV2, along with that of the pilot participants, some changes were made to the CVSI-V1, resulting in a second version - the CVSI-V2. The CVSI-V2 was administered to EV3 who provided both quantitative and qualitative feedback on the measure regarding its face, content and construct validity. EV3 was a male, Master's level registered psychologist based in Alberta, Canada, who had completed initial training (Level 1) with Patrick Carnes for status as a Certified Sex Addiction Therapist (CSAT), was a certified sex therapist, and indicated that approximately 20-25% of his clients in his practice were in treatment for sex or cybersex addiction.

Instruments.

Demographic survey. The demographic survey was composed of 18 question items, some with sub-questions, and was administered as the first of the three surveys to pilot participants (see online pilot demographic survey in Appendix Q). The first two question items of the demographic survey were selection/filter questions used to identify whether those individuals who consented to be a part of the pilot study actually met the selection criteria to do so. These filter items included questions about whether the participant was (1) a Ph.D. student and (2) currently enrolled in either a counselling or clinical

psychology program, and if yes, which one. Items 3 through 18 were used to describe the pilot participants and were composed of questions about education, age, gender, ethnicity, marital status, sexual orientation, population of specialization, current workplace setting, computer/Internet familiarity and usage, and amount of training received in sex/cybersex addiction. Some constructs, like ethnicity and computer and Internet comfort and familiarity, were measured through the use of more than one question.

How a person sees their ethnicity can be very complex. A person who was born in one country may identify with the ethnicity of their other newly adopted country. By the same token a person who has been born and raised in one country may still identify their ethnicity to be that of their ancestors or at least several generations before them who may have hailed from another country entirely. In light of this, the question of ethnicity was tackled in two parts, composed of participants' self-reported ethnicity and how long they had lived in Canada.

How well a person is familiar with computers and the Internet may influence their understanding of the sheer volume of cybersex available for users and, as a result, how it may become addictive. Six questions around these variables were designed to measure participant familiarity and comfort with using the computer and the Internet. Also, it was expected that those with strong computer/Internet skills would select more purposes for which they use the computer/Internet, as a reflection of their capabilities, than would someone with less computer/Internet skills (Potosky & Bobko, 1998; Smith, Caputi, Crittenden,

Jayasuriya, & Rawstorne, 1999). It was anticipated that the number of hours of use and number of purposes selected would serve as an alternative descriptive indication and confirmation of participants' comfort and expertise of use of the computer (Potosky & Bobko, 1998; Smith, Caputi, Crittenden, Jayasuriya, & Rawstorne, 1999) and Internet and augment the self-report questions regarding participants' rated level of comfort with their use.

Modified Sexual Opinion Survey-Revised (SOS-R-M). The Sexual Opinion Survey – Revised (SOS-R; Appendix R) is a 21-item measure of erotophobic-erotophilic tendencies in response to sexual cues along a 7-point Likert scale dimension of evaluation and emotion (Fisher, White, et al., 1988). Scores for this measure range from 0 to 126, with scores towards 0 indicating a negative response to erotic cues (erotophobia) and scores towards 126 indicating a positive response to erotic cues (erotophilia). The SOS-R is composed of three main factor clusters: open sexual display, sexual variety, and homoeroticism, and they account for 34%, 11% and 7% of the overall variance in SOS-R scores respectively (Gilbert & Gamache, 1984; Fisher, White, et al., 1988). The SOS-R is based on the original Sexual Opinion Survey (SOS) and the correlation between the SOS and the SOS-R is very high, r (321) = 0.92, $p < .001$, leading the SOS-R to be recommended for future research over the SOS (Fisher, White, et al., 1988). As there is no mention of sexual content accessed through the Internet in the SOS-R, one of the changes made in the Modified Sexual Opinion Survey – Revised (SOS-R-M; Appendix S; Yassa, 2005) is in the explanation of the term erotica in Questions 1, 2, 15, and 20. The delimiter in those questions of "sexually explicit

books, movies, etc." was replaced with "sexually explicit Internet sites, chat rooms, books, magazines, movies, etc." For similar reasons, in Question 9 the delimiter of "movie" was replaced with "movie/on-line video/Internet site/on-line Chat/magazine/book."

Client Vignette Scoring Instrument - Version 1 (CVSI-V1). As indicated earlier, the CVSI-V1 measures both participants' identifications and perceptions of the presenting problem via two questions (with 27 sub-items under Question 1 and 29 sub-items under Question 2) in response to each of three fictional case (Sophie, Bill, and Jeff in order from case 1 to 3 respectively) adapted with permission from Goodman (Goodman, 1998b). Each vignette presents the case details of an individual experiencing symptoms related to Cybersex Addiction (CSA), Major Depressive Disorder (MDD) and Obsessive Compulsive Disorder (OCD). The primary focus of the CVSI-V1 is to determine the ability of participants to respond accurately to the presence or absence of CSA criteria in each of the case vignettes, followed by those of MDD and OCD. For more detail on the CVSI-V1, please see the section entitled "The Client Vignette Scoring Instrument (CVSI)" at the beginning of Chapter 3 of this dissertation.

Procedure.

Sample Recruitment. A sample of 27 Ph.D. level graduate students in Counselling and Clinical Psychology from the University of Alberta and the University of Calgary were recruited via postings to three different department graduate student listservs (Educational Psychology, Clinical Psychology, and Applied Psychology). In addition, visits were made to classrooms of four

different Ph.D. level courses (based on appropriateness and accessibility) at the universities and professors emailed all enrolled students the link to the study afterwards to preserve participant anonymity. Finally, pilot participants were also recruited online via a posting to the Canadian Psychological Association (CPA) Student Section listserv and one insertion in the Canadian Psychological Association (CPA) Student Section e-Newsletter (estimated circulation of approximately 1842 students). The CPA is a national voluntary membership professional association for those who practice, research and study psychology.

While initially the intent had been to provide participants with the pilot surveys both online and via paper copy by mail it was later deemed more cost effective and efficient given the goal sample size to only provide an online version. In addition, providing access to student names, emails and mailing information for distribution of the surveys either by the professors or by the researcher were judged to be in violation of FOIPP, reduced appearance of anonymity, increased opportunity for discussion between potential pilot participants, and, because of the sensitive nature of the SOS-R-M, may likely have reduced honesty in their responses.

Each graduate student participant completed the demographic survey, as well as the Modified version of the Sexual Opinion Survey – Revised (SOS-R-M) and the CVSI-V1. All measures were made available to pilot participants online only. Results of the CVSI-V1 were analyzed for internal reliability. Results of the SOS-R-M and the demographic survey were analyzed only for descriptive information regarding the pilot participants.

It should be noted here that all three Expert Validators were recruited via cold call and/or direct email and completed only the CVSI measure.

Ethical considerations. The ethical procedures outlined here are a reflection of the values, principles and standards derived from the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research *et al.*, 1998, with 2000, 2002, & 2005 amendments), the Canadian Psychological Association (CPA) Canadian Code of Ethics for psychologists (Canadian Psychological Association, 2000), and the University of Alberta Standards for the Protection of Human Research Participants (University of Alberta, n.d.). This research project was designed in agreement with the guidelines and requirements therein.

Free and informed consent. Pilot participants were provided an online consent form (Appendix T) indicating that the purpose of the research was to examine therapists' identification of the presenting problems of clients using fictional vignettes and the relationship that therapists personal and professional characteristics may play in those identifications. Pilot participants were advised that their participation would involve the completion of three questionnaires which would include personal and professional demographic questions, questions about their sexual attitudes, and three written client vignettes and subsequent questions about participants' thoughts on the issue for the client represented in the vignette. They were also informed in the consent form of the potential risks (low to nil) of participating, how their confidentiality would be protected, the investment of time (30 – 45 minutes), the benefits of participation, their rights as

participants, information about withdrawal (e.g., they would be unable to due to anonymity), the researchers plans for the data, and who to contact should they have further questions. Pilot participants were provided the opportunity to freely accept or decline participation with no negative consequences.

Partial disclosure. Partial disclosure was considered a necessity in the pilot phase of this study, as well as in the study itself, as full disclosure of the research goal would bias participants towards perceiving the presence of cybersex addiction in the vignettes, thereby defeating the purpose of the research. However, it was deemed that the risks to the pilot participants of such partial disclosure would be minimal to nil due to their training as psychologists, which rendered them a non-vulnerable population. The risks of partial disclosure therefore were assessed to not outweigh the benefits to the research.

Pilot Participants were advised in the online consent form that they could go to an indicated web address as of July 1, 2010 to read a full explanation of the study, and that this web address and the explanation therein would be available to access a period of one month. The date chosen to make the debrief website available (July 1, 2010) was based on a cut-off date after which no more data would be collected by the researcher. This ensured that all participants (pilot and otherwise) would have access at the same time to the debrief, thereby reducing the chances that the real purpose of the study might be leaked to potential future participants who may have not yet completed the surveys. The debrief website was left up for one month which, it was determined, would allow interested participants adequate time to access it.

Pilot participants were advised in the online consent form and at the end of the online surveys that once they clicked "Done" and submitted their completed surveys to the researcher that withdrawal would not be an option. Pilot participants were advised that this inability to withdraw their data after submission was due to the anonymity of the surveys and the fact that the researcher had not collected any information linking the surveys to the individual participant.

Right to withdraw. All efforts were made to minimize any potential harm or risk to the pilot research participants, although it was acknowledged in the online consent form that some (albeit, it was anticipated, few) pilot participants might possibly experience mild discomfort with the sexual content of some of the survey questions (i.e., those of the SOS-R-M). Pilot participants were advised in the online consent form that if, at any time, they decided they do not wish to continue with the surveys they were free to exercise their right to withdraw by simply discontinuing their online surveys session at no consequence to themselves.

Anonymity. Individuals recruited to respond to self-report surveys containing sensitive (e.g., sexual) material are more likely to participate when anonymity, rather than merely confidentiality, is provided by researchers (Durant et al., 2002). Steps were taken to make sure of pilot participant anonymity by even removing the function in the online surveys that drops a cookie into the participants' computer cache. Cookies can (and often are in online research and other websites) used to track visitors to a website (in this case the survey website

link) by creating a record of the IP (Internet protocol) address from which the individual accessed the site. This creates a record of the visitors' computer and Internet connection location. Despite the potential although slim risk of a participant choosing to complete all the surveys more than once (multiple responders), cookie tracking was disabled for this pilot study as it was more important to guarantee participants both the appearance of anonymity as well as the reality of it. Were pilot participants to exit or close down the survey prematurely and attempt to return and initiate it again at a future time and then be given a message that they could not do so as the system was aware they had already been to the site, it was felt this could undermine the appearance of anonymity. Compromised appearance of anonymity may then have reduced the potential overall respondent rate (despite the fact that simple placement of a tracking cookie would not in any way provide the researcher with location or identity information about the participant).

Additionally, pilot participants were assured of their anonymity throughout this study, both in the recruitment materials and process (emails, e-newsletters, class presentations) as well as in the online consent form and at the end of the surveys. At no point were they asked to enter any specifically identifying information about them during the survey process and the online survey website generated for each pilot participant a random string of numbers to act as an ID.

Privacy and confidentiality. Pilot participants self-selected to participate by clicking on the link provided in the e-newsletters and emails they received.

Despite there being no identifying information collected via any of the measures, all pilot surveys submitted were stored securely in a locked filing cabinet, and participants were assured in the online consent form that this would be the case for a period of no less than five years.

Incentive. Pilot participants were advised that the benefit to them of participating included the knowledge that they had contributed something of value to the knowledge base of the profession and assisted indirectly in helping other therapists (including other graduate students and seasoned professionals) learn about their role in the therapeutic assessment process. No other incentive was provided in part due to the fact that this may have required collection or access by the researcher of some identifying information.

Results of Phase I (the pilot).

Sample demographics. In the pilot, data from the demographic survey and the SOS-R-M were collected only as descriptive information of the graduate student pilot participants because the measure being piloted was the CVSI-V1. The goal was to have 10 participants for the pilot of the CVSI-V1. By clicking on the link sent out, 36 showed interest in the study and consented to participate. However, of these 36 pilot respondents, only 27 (75%) met selection/filtering criteria of being a Ph.D. student and currently enrolled in either a Counselling Psychology or Clinical Psychology program. Of those 27 pilot respondents who consented to participate in the study and met selection criteria, three (11.1%) participants were enrolled in Clinical Psychology Ph.D. program and 24 (88.9%) participants were enrolled in a Counselling Psychology Ph.D. program. In

addition, 26 (96.3%) of the pilot participants endorsed having a Master's degree as their highest education completed, and one (3.7%) indicated that they had earned a Ph.D. degree.

Since it is unknown how many students received the recruitment email, the exact response rate for participation in the pilot is impossible to calculate. The time it took pilot participants to complete the surveys ranged from 15 seconds to 24 hours 50 minutes and 47 seconds. Mean completion time for all surveys was 1 hour 19 minutes and 26 seconds (*SD* = 4 hours 17 minutes and 2.86 seconds) and Median completion time was 18 minutes and 51 seconds.

Twenty-seven pilot participants completed the first survey presented, which was the demographic survey, while 25 completed the SOS-R-M, which was the second measure presented (reflecting a 7.4% attrition rate to this point). Pilot participants were prohibited from progressing on to the next page, and the subsequent measure, unless they completed each item on each page of the online surveys in the order presented. The CVSI-V1 was the third measure presented and participants were presented with the case of Sophie first (case 1), then with the case of Bill (case 2), and lastly the case of Jeff (case 3) and each case was immediately followed by the questions directly applicable to it. The first case presented in the CVSI-V1 (Sophie) was completed by 18 pilot participants (reflecting 28% further attrition from previous measure, and 33.3% overall total attrition to this point). The second case presented in the CVSI-V1 (Bill) was completed by 14 pilot participants (reflecting 22.2% further attrition from the first CVSI-V1 case presented, and 48.15% overall total attrition to this point). The

third and final case presented in the CVSI-V1 (Jeff) was completed by 12 pilot participants (reflecting 14.28% further attrition from the second CVSI-V1 case presented, and 55.55% overall total attrition to this point). A total of 44.44% of the 27 pilot participants who fit selection criteria completed all three surveys.

In response to population of specialization, when asked to select all that applied, 85.2% (23) of pilot participants indicated adults, 11.1% (3) indicated couples, 7.4% (2) indicated families, 18.5% (5) indicated children, 18.5% (5) indicated adolescents, and 14.8% (4) indicated that they had no specific population in which they specialized. In response to current workplace setting, again when asked to select all that applied, 48.1% (13) of pilot participants indicated that they are not currently working, 3.7% (1) indicated that they are working in a non-psychology related job, 11.1% (3) indicated that they work in the outpatient ward of a hospital, 3.7% (1) indicated they work in a correctional facility, 18.5% (5) indicated they work in a private practice setting, 7.4% (2) indicated they work in a non-profit agency, 22.2% (6) indicated they work in a school setting, and 7.4% (2) indicated that they work in a community service centre.

The mean age reported by pilot participants was 30.3 years (SD = 5.97) and ranged from 25 to 53 years, skewing young with 88.9% aged 35 years or younger and 92.6% aged 40 years or younger. The median age reported was 28 years. The significant majority of pilot participants were female (92.6%, n = 25), while only 7.4% (2) were male.

Ethnicity is a complex construct and so was based on participants declared

ethnicity, as well as their stated number of years lived in Canada. In response to ethnicity, 77.8% (21) of pilot participants identified as Canadian, 7.4% (2) identified as Western European, and 3.7% (1) identified with each of the ethnic groups of Eastern European, Middle-Eastern/Arab, South Asian, and East and Southeast Asian. The reported number of years lived in Canada ranged from 21 years to 53 years with a mean of 29.67 years (*SD* = 6.04) and a median of 28 years. Number of years lived in Canada closely matched the age of participants reflecting the majority of participants who self-identified as Canadian.

Regarding current relationship status, the majority of participants (37%, *n* = 10) said they were married, 14.8% (4) said they were in a common-law relationship, 22.2% (6) said they were in a monogamous relationship, 3.7% (1) reported being divorced, and 22.2% (6) endorsed being single. Overall, 74.1% (20) of participants endorsed being in some sort of relationship with a partner, while 25.9% (7) endorsed not being currently in a relationship. Sexual orientation was measured using a 7-point Likert scale which ranged from 1 (*purely heterosexual*) to 7 (*purely homosexual*). In response to sexual orientation 70.4% (19) of pilot participants self-identified as purely heterosexual, 25.9% (7) identified as being a "2" on the 7-point Likert (*mostly heterosexual*), and 3.7% (1) identified as being a "5" on the 7-point Likert (*more homosexual than heterosexual*).

Familiarity with computers and the Internet was measured using four approaches: self-reported comfort with use; number of hours per week used for personal uses; number of hours per week used for professional purposes, and; the

total number of purposes for which each is generally used. Comfort with using the computer and Internet each was scored using a 5-point Likert scale which ranged from 1 (*extremely uncomfortable*) to 5 (*extremely comfortable*). The majority (66.7%, *n* = 18) of pilot participants reported feeling extremely comfortable with using the computer, while 11.1% (3) reported feeling extremely uncomfortable, 3.7% (1), 7.4% (2) and 11.1% (3) reported scores of "2", "3" and "4", respectively regarding their comfort with using the computer. Again, the majority of pilot participants (70.4%, *n* = 19) reported feeling extremely comfortable with using the Internet, while 11.1% (3) reported feeling extremely uncomfortable. Another 3.7% (1) reported scores of "2" and "3" each, and 11.1% (3) reported scores of "4" regarding their comfort with using the Internet.

In response to number of hours per week of personal computer use, 40.7% (11) of pilot participants reported spending 1-5 hours, 25.9% (7) reported spending 6-10 hours, 3.7% (1) reported spending 11-20 hours, 18.5% (5) reported spending 21-30 hours, and 11.1% (3) reported spending 31-40 hours. Regarding the number of hours per week of professional computer use, 14.8% (4) of pilot participants reported spending 1-5 hours and 6-10 hours each, 29.6% (8) reported spending 11-20 hours, 11.1% (3) reported spending 21-30 hours, 31-40 hours and 41-50 hours each, and 7.4% (2) reported spending more than 50 hours. In response to number of hours spent per week in personal Internet use, 37% (10) of pilot participants reported spending 1-5 hours, 33.3% (9) reported spending 6-10 hours, 7.4% (2) reported spending 11-20 hours, 14.8% (4) reported spending 21-30 hours, and 7.4% (2) reported spending 31-40 hours. Regarding the number of

hours per week of professional Internet use, 29.6% (8) of pilot participants reported spending 1-5 hours, 40.7% (11) reported spending 6-10 hours, 25.9% (7) reported spending 11-20 hours, and 3.7% (1) reported spending 21-30 hours.

The total number of purposes for which pilot participants reported using the computer ranged from 4 to 22, with a mean of 9.41 (*SD* = 4.57) and a median and mode of 8. The total number of purposes for which participants used the Internet ranged from 6 to 24, with a mean of 11.15 (*SD* = 4.55) and a median and mode of 10.

The majority of pilot participants (51.9%, *n* = 14) reported receiving no training at all in Sex/Cybersex Addiction on a 6-point Likert scale in which "0" indicated *no training at all* and "6" indicated *extensive training*, while 25.9% (7) rated themselves a "1", 14.8% (7) rated themselves a "2", and 3.7% (1) rated themselves a "3" and a "4" each.

The SOS-R-M is composed of 21 items that use a 7-point Likert scale which ranges from 1 (*I strongly agree*) to 7 (*I strongly disagree*). Total scores range from 0 (*most erotophobic*) to 126 (*most erotophilic*). Pilot participants' (*N* = 25) scores on the SOS-R-M ranged from 44 to 105 with a mean of 75.96 (*SD* = 14.16), a median of 79 and mode of 67.

CVSI-V1 Question 1. Question 1 of CVSI-V1 focused on measuring the degree to which the participants believed that each of the problems (i.e., criterion of CSA, MDD-SE and OCD) listed contributed to the overall presenting problem of the client in the case vignette immediately preceding (Sophie, Bill or Jeff). Likert ratings for this question ranged from 0 to 4 in which a minimum

endorsement of 3 (*somewhat contributing*) was interpreted to mean the participant did indeed believe the specific problem (i.e., criterion) listed had contributed to the client's overall presenting problem in the relevant case vignette.

CSA items for Sophie. Eighteen pilot participants completed the nine CSA sub-items under Question 1of the CVSI-V1 case one. CSA sub-items included Items 1, 4, 7, 10, 13, 16, 19, 22, and 25 that corresponded to CSA criteria 1a, 1b, 2a, 2b, 3, 4, 5, 6, and 7, respectively (see Appendix J). As indicated earlier in this chapter, case one of the CVSI-V1 was that of Sophie and the case was designed to reflect an endorsement of CSA with four CSA symptom criteria built in (Items 16, 19, 22 and 25; the minimum necessary for endorsement is 3), reflecting a medium level signal strength for CSA.

Results of the CVSI-V1 Question 1 CSA items Cronbach alpha score for the case of Sophie were high at 0.821. The only item, which if deleted would have increased the Cronbach alpha score, was Item 10 (Criterion 2b: The same [or a closely related] sexual behaviour is engaged in to relieve or avoid withdrawal symptoms) and it would only have increased the Cronbach alpha score by 0.007 to 0.828, which was deemed not a significant enough increase to warrant deletion.

For Question 1 in the case of Sophie, pilot participants gave a mean Likert rating for Item 1 (Criterion 1a: A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect) of 3.28 (SD = 0.75), and for Item 4 (Criterion 1b: Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity) the mean Likert rating was 3.00 (SD = 0.77), indicating that both items (i.e., CSA

symptom criteria) met the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Sophie. Item 7 (Criterion 2a: Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour) showed a mean Likert rating by pilot participants of 2.67 (*SD* = 0.84), and the Item 10 (Criterion 2b: The same [or a closely related] sexual behaviour is engaged in to relieve or avoid withdrawal symptoms) mean Likert rating was 2.78 (*SD* = 1.17), indicating that both items (i.e., CSA symptom criteria) did not meet the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Sophie. The mean Likert rating endorsed by pilot participants for Item 13 (Criterion 3: The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended) was 3.39 (*SD* = 0.70), and for Item 16 (Criterion 4: There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour) the mean Likert rating was 3.00 (*SD* = 0.91). Item 19 (Criterion 5: A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects) had a mean Likert rating among pilot participants of 2.94 (*SD* = 0.80). The mean Likert rating endorsed among pilot participants for Item 22 (Criterion 6: Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour) was 3.50 (*SD* = 0.86), and for Item 25 (Criterion 7: The psychological problem that is likely to have been caused or

exacerbated by the online sexual behaviour continues despite knowledge of its consequences) the mean Likert rating was 3.33 (*SD* = 0.69).

Using CSA Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean CSA Subscale score across pilot participants for the case of Sophie (case 1) was 22.72 (*SD* = 3.88), the median was 23.50, and the mode was 26. CVSI-V1 Question 1 CSA Subscale scores for the case of Sophie ranged from 14 to 28. It should be noted that the CVSI-V1 CSA Subscale ranges from 0 (seven items at a Likert rating of "0" each) to 28 (seven items at a Likert rating of "4"), and that for the case of Sophie the actual built in signal strength (i.e., CSA Subscale score that represents the actual number of CSA symptom criteria built in to the case by design) equals 12 (four items at a minimum Likert rating of "3"). As indicated earlier in this chapter, the minimum CSA Subscale score that indicates an endorsement by participants of the perception of CSA in a case is 9 (three items at a minimum Likert rating of "3"). Skewness of the CVSI-V1 Question 1 CSA Subscale scores for the case of Sophie equaled -0.805 (standard error of skewness = 0.536), and Fisher's measure of skewness for the same was calculated to be -1.502. Kurtosis of the CVSI-V1 Question 1 CSA Subscale scores in response to the case of Sophie equaled -0.094 (standard error of kurtosis = 1.038), and Fisher's measure of kurtosis for the same was calculated to be -2.474.

CSA items for Bill. For Question 1 of the CVSI-V1 case 2, 14 pilot participants completed the nine CSA sub-items. As indicated earlier in this chapter, case 2 of the CVSI-V1 was that of Bill and the case was designed to

reflect an endorsement of CSA with all nine CSA symptom criteria built in (Items 1, 4, 7, 10, 13, 16, 19, 22 and 25; the minimum necessary for endorsement is 3), reflecting a maximum level signal strength for CSA.

Results of the CVSI-V1 Question 1 CSA items Cronbach alpha score for the case of Bill were high at 0.900. The only item, which if deleted would have increased the Cronbach alpha score was Item 22 (Criterion 6: Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour) and it would only have increased the Cronbach alpha score by 0.003 to 0.903, which was considered not significant enough to warrant its deletion.

For Question 1 in the case of Bill, pilot participants gave a mean Likert rating for Item 1 (Criterion 1a: A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect) of 3.50 (*SD* = 0.76), and for Item 4 (Criterion 1b: Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity) the mean Likert rating was 3.21 (*SD* = 0.89), indicating that both items (i.e., CSA symptom criteria) met the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Bill. Item 7 (Criterion 2a: Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour) showed a mean Likert rating by pilot participants of 3.36 (*SD* = 0.84), and the Item 10 (Criterion 2b: The same (or a closely related) sexual behaviour is engaged in to relieve or

avoid withdrawal symptoms) mean Likert rating was 3.14 (*SD* = 1.10). Item 13 (Criterion 3: The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended) showed a mean Likert rating by pilot participants of 3.57 (*SD* = 0.65), Item 16 (Criterion 4: There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour) of 3.43 (*SD* = 0.76), and Item 19 (Criterion 5: A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects) mean Likert rating was 3.64 (*SD* = 0.63). The mean Likert rating endorsed by pilot participants for Item 22 (Criterion 6: Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour) was 3.64 (*SD* = 0.75), and for Item 25 (Criterion 7: The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences) the mean Likert rating was 3.43 (*SD* = 0.76).

Using CSA Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean CSA Subscale score across pilot participants for the case of Bill (case 2) was 24.71 (*SD* = 3.83), the median was 26, and the mode was 28. As in the case of Sophie, CVSI-V1 Question 1 CSA Subscale scores for the case of Bill ranged from 14 to 28. Again, the CVSI-V1 CSA Subscale ranges from 0 (seven items at a Likert rating of “0” each) to 28 (seven items at a Likert rating of “4”), and for the case of Bill the actual built in signal strength as per protocol 2 (i.e., CSA Subscale score that represents the actual number of CSA symptom criteria

built in to the case by design) equals 21 (seven items at a minimum Likert rating of "3"). As indicated earlier in this chapter, the minimum CSA Subscale score that indicates an endorsement by participants of the perception of CSA in a case is 9 (three items at a minimum Likert rating of "3"). Skewness of the CVSI-V1 Question 1 CSA Subscale scores for the case of Bill equaled -1.822 (standard error of skewness = 0.597), and Fisher's measure of skewness for the same was calculated to be -3.052. Kurtosis of the CVSI-V1 Question 1 CSA Subscale scores in response to the case of Bill equaled 4.065 (standard error of kurtosis = 1.154), and Fisher's measure of kurtosis for the same was calculated to be 3.523.

CSA items for Jeff. For Question 1 of the CVSI-V1 case 3, 12 pilot participants completed the nine CSA sub-items. As indicated earlier in this chapter, case 3 of the CVSI-V1 was that of Jeff and the case was designed to reflect no endorsement of CSA with only two CSA symptom criteria built in (Items 19 and 25; the minimum necessary for endorsement is 3), reflecting a low level signal strength for CSA.

Results of the CVSI-V1 Question 1 CSA items Cronbach alpha score for the case of Jeff were high at 0.906. The only item, which if deleted would have increased the Cronbach alpha score was Item 10 (Criterion 2b: The same [or a closely related] sexual behaviour is engaged in to relieve or avoid withdrawal symptoms) and it would only have increased the Cronbach alpha score by 0.031 to 0.937, which was not considered significant enough to warrant its deletion.

For Question 1 in the case of Jeff, pilot participants gave a mean Likert rating for Item 1 (Criterion 1a: A need for markedly increased amount or intensity

of the online sexual behaviour to achieve the desired effect) of 1.67 (*SD* = 1.23), and for Item 4 (Criterion 1b: Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity) the mean Likert rating was 1.50 (*SD* = 1.31), indicating that both items (i.e., CSA symptom criteria) did not meet the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Jeff. Item 7 (Criterion 2a: Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour) showed a mean Likert rating by pilot participants of 1.75 (*SD* = 1.29), and the Item 10 (Criterion 2b: The same [or a closely related] sexual behaviour is engaged in to relieve or avoid withdrawal symptoms) mean Likert rating was 2.50 (*SD* = 0.91). Item 13 (Criterion 3: The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended) showed a mean Likert rating by pilot participants of 1.75 (*SD* = 1.29), Item 16 (Criterion 4: There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour) of 1.83 (*SD* = 1.40), and Item 19 (Criterion 5: A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects) mean Likert rating was 2.08 (*SD* = 1.44). The mean Likert rating endorsed by pilot participants for Item 22 (Criterion 6: Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour) was 2.08 (*SD* = 1.38), and for Item 25 (Criterion 7: The psychological

problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences the mean Likert rating was 2.50 (*SD* = 1.38).

Using CSA Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean CSA Subscale score across pilot participants for the case of Jeff (case 3) was 14.83 (*SD* = 6.98), the median was 15, and the mode was 15. CVSI-V1 Question 1 CSA Subscale scores for the case of Jeff ranged from 4 to 28. The CVSI-V1 CSA Subscale ranges from 0 (seven items at a Likert rating of "0" each) to 28 (seven items at a Likert rating of "4"), and for the case of Jeff the actual built in signal strength (i.e., CSA Subscale score that represents the actual number of CSA symptom criteria built in to the case by design) equals 6 (two items at a minimum Likert rating of "3"). Again, the minimum CSA Subscale score that indicates an endorsement by participants of the perception of CSA in a case is 9 (three items at a minimum Likert rating of "3"). Skewness of the CVSI-V1 Question 1 CSA Subscale scores for the case of Jeff equaled 0.078 (standard error of skewness = 0.637), and Fisher's measure of skewness for the same was calculated to be 0.122. Kurtosis of the CVSI-V1 Question 1 CSA Subscale scores in response to the case of Jeff equaled -0.003 (standard error of kurtosis = 1.232), and Fisher's measure of kurtosis for the same was calculated to be -0.002.

MDD items for Sophie. For Question 1 of the CVSI-V1 case 1, 18 pilot participants completed the 10 MDD sub-items. MDD sub-items included Items 2, 5, 8, 11, 14, 17, 20, 23, 26, 27 which corresponded to MDD criteria A(a1), A(a2), A(a3), A(a4), A(a5), A(a6), A(a7), A(a8), A(a9), and A(a-c), respectively (see

Appendix K). As indicated earlier in this chapter, case 1 of the CVSI-V1 was that of Sophie and the case was designed to not reflect an endorsement of MDD with five MDD symptom criteria, but not criterion A(a-c), built in (Items 5, 8, 11, 20 and 23; the minimum necessary for endorsement is five plus criterion A[a-c]). MDD symptom criterion A(a-c) (Item 27) requires that the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Results of the CVSI-V1 Question 1 MDD items Cronbach alpha score for the case of Sophie were high at 0.853. The only item, which if deleted would have increased the Cronbach alpha score was Item 23 (Criterion A[a8]: Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others [during the same 2-week period and representing a change from previous functioning]) and it would only have increased the Cronbach alpha score by 0.014 to 0.867, which was deemed not significant enough to warrant its deletion.

For Question 1 in the case of Sophie, pilot participants gave a mean Likert rating for Item 2 (Criterion A[a1]: Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others [during the same 2-week period and representing a change from previous functioning]) of 2.61 (*SD* = 1.20), and for Item 5 (Criterion A[a2]: Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others [during the same 2-week period and representing a change from previous functioning]) the

mean Likert rating was 2.56 (*SD* = 1.20), indicating that both items (i.e., MDD symptom criteria) did not meet the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Sophie. Item 8 (Criterion A[a3]: Significant weight loss when not dieting or weight gain [e.g., a change of more than 5% of body weight in a month], or decrease or increase in appetite nearly every day [during the same 2-week period and representing a change from previous functioning]) showed a mean Likert rating by pilot participants of 2.33 (*SD* = 1.14), and the Item 11 (Criterion A[a4]: Insomnia or hypersomnia nearly every day [during the same 2-week period and representing a change from previous functioning]) mean Likert rating was 2.50 (*SD* = 1.25). The mean Likert rating endorsed by pilot participants for Item 14 (Criterion A[a5]: Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down [during the same 2-week period and representing a change from previous functioning]) was 2.22 (*SD* = 1.00), and for Item 17 (Criterion A[a6]: Fatigue or loss of energy nearly every day [during the same 2-week period and representing a change from previous functioning]) the mean Likert rating was 2.33 (*SD* = 1.03). Item 20 (Criterion A[a7]: Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick [during the same 2-week period and representing a change from previous functioning]) had a mean Likert rating among pilot participants of 2.89 (*SD* = 0.96). The mean Likert rating endorsed among pilot participants for Item 23 (Criterion A[a8]: Diminished ability to think

or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others [during the same 2-week period and representing a change from previous functioning]) was 2.89 (*SD* = 0.90), and for Item 26 (Criterion A[a9]: Recurrent thoughts of death [not just fear of dying], recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide [during the same 2-week period and representing a change from previous functioning]) the mean Likert rating was 1.56 (*SD* = 1.25). The mean Likert rating for Item 27 (Criterion A[a-c]: Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure [during the same 2-week period and representing a change from previous functioning]) was 2.94 (*SD* = 1.260) among pilot participants.

Using MDD Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean MDD Subscale score across pilot participants for the case of Sophie (case 1) was 17.89 (*SD* = 15.19), the median was 25, and the mode was 0. CVSI-V1 Question 1 MDD Subscale scores for the case of Sophie ranged from 0 to 40. It should be noted that the CVSI-V1 MDD Subscale ranges from 0 (10 items at a Likert rating of "0" each) to 40 (10 items at a Likert rating of "4"), and that for the case of Sophie the actual built in signal strength (i.e., MDD Subscale score that represents the actual number of MDD symptom criteria built in to the case by design) equals 15 (five items at a minimum Likert rating of "3"). As indicated earlier in this chapter, the minimum MDD Subscale score that indicates an endorsement by participants of the perception of MDD in a case is 18 (five

items plus Item 27 at a minimum Likert rating of "3"). Skewness of the CVSI-V1 Question 1 MDD Subscale scores for the case of Sophie equaled -0.266 (standard error of skewness = 0.536), and Fisher's measure of skewness for the same was calculated to be -0.496. Kurtosis of the CVSI-V1 Question 1 MDD Subscale scores in response to the case of Sophie equaled -1.783 (standard error of kurtosis = 1.038), and Fisher's measure of kurtosis for the same was calculated to be -1.718.

MDD items for Bill. For Question 1 of the CVSI-V1 case 2, 14 pilot participants completed the 10 MDD sub-items. As indicated earlier in this chapter, case 2 of the CVSI-V1 was that of Bill and the case was designed to not reflect an endorsement of MDD with five MDD symptom criteria, but not criterion A(a-c), built in (Items 2, 11, 14, 23 and 26; the minimum necessary for endorsement is five plus criterion A[a-c]). MDD symptom criterion A(a-c) (Item 27) requires that the "symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."

Results of the CVSI-V1 Question 1 MDD items Cronbach alpha score for the case of Bill were high at 0.858. The only items, which if deleted would have increased the Cronbach alpha score were Item 8 (Criterion A[a3]: Significant weight loss when not dieting or weight gain [e.g., a change of more than 5% of body weight in a month], or decrease or increase in appetite nearly every day [during the same 2-week period and representing a change from previous functioning]) and Item 20 (A[a7]: Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-

reproach or guilt about being sick [during the same 2-week period and representing a change from previous functioning]), however, they would each only have increased the Cronbach alpha score by, respectively, 0.002 and 0.003 to 0.860 and 0.861, respectively, which were deemed not significant enough increases to warrant either deletion.

For Question 1 in the case of Bill, pilot participants gave a mean Likert rating for Item 2 (Criterion A[a1]: Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others [during the same 2-week period and representing a change from previous functioning]) of 3.21 (*SD* = 0.98), and for Item 5 (Criterion A[a2]: Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others [during the same 2-week period and representing a change from previous functioning]) the mean Likert rating was 3.14 (*SD* = 0.95), indicating that both items (i.e., MDD symptom criteria) met the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Bill. Item 8 (Criterion A[a3]: Significant weight loss when not dieting or weight gain [e.g., a change of more than 5% of body weight in a month], or decrease or increase in appetite nearly every day [during the same 2-week period and representing a change from previous functioning]) showed a mean Likert rating by pilot participants of 1.43 (*SD* = 1.28), and the Item 11 (Criterion A[a4]: Insomnia or hypersomnia nearly every day [during the same 2-week period and representing a change from previous functioning]) mean Likert rating was 3.29

(*SD* = 0.73), indicating that Item 8 (i.e., MDD symptom criterion) did not meet the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Bill, but that Item 11 did. The mean Likert rating endorsed by pilot participants for Item 14 (Criterion A[a5]: Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down [during the same 2-week period and representing a change from previous functioning]) was 3.14 (*SD* = 1.17), and for Item 17 (Criterion A[a6]: Fatigue or loss of energy nearly every day [during the same 2-week period and representing a change from previous functioning]) the mean Likert rating was 2.64 (*SD* = 1.28). Item 20 (Criterion A[a7]: Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick [during the same 2-week period and representing a change from previous functioning]) had a mean Likert rating among pilot participants of 2.86 (*SD* = 0.86). The mean Likert rating endorsed among pilot participants for Item 23 (Criterion A[a8]: Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others [during the same 2-week period and representing a change from previous functioning]) was 2.93 (*SD* = 0.83), and for Item 26 (Criterion A[a9]: Recurrent thoughts of death [not just fear of dying], recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide [during the same 2-week period and representing a change from previous functioning]) the mean Likert rating was 2.93 (*SD* = 1.14). The mean Likert rating for Item 27 (Criterion A[a-c]:

Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure [during the same 2-week period and representing a change from previous functioning]) was 3.36 (*SD* = 1.01) among pilot participants.

Using MDD Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean MDD Subscale score across pilot participants for the case of Bill (case 2) was 22.86 (*SD* = 15.71), the median was 29.50, and the mode was 0. CVSI-V1 Question 1 MDD Subscale scores for the case of Bill ranged from 0 to 40. Again, it should be noted that the CVSI-V1 MDD Subscale ranges from 0 (10 items at a Likert rating of "0" each) to 40 (10 items at a Likert rating of "4"), and that for the case of Bill the actual built in signal strength (i.e., MDD Subscale score that represents the actual number of MDD symptom criteria built in to the case by design) equals 15 (five items at a minimum Likert rating of "3"). As indicated earlier in this chapter, the minimum MDD Subscale score that indicates an endorsement by participants of the perception of MDD in a case is 18 (five items plus Item 27 at a minimum Likert rating of "3"). Skewness of the CVSI-V1 Question 1 MDD Subscale scores for the case of Bill equaled -0.756 (standard error of skewness = 0.597), and Fisher's measure of skewness for the same was calculated to be -1.266. Kurtosis of the CVSI-V1 Question 1 MDD Subscale scores in response to the case of Bill equaled -1.210 (standard error of kurtosis = 1.154), and Fisher's measure of kurtosis for the same was calculated to be -1.049.

MDD items for Jeff. For Question 1 of the CVSI-V1 case 3, 12 pilot participants completed the 10 MDD sub-items. As indicated earlier in this

chapter, case 3 of the CVSI-V1 was that of Jeff and the case was designed to reflect an endorsement of MDD with five MDD symptom criteria plus criterion A(a-c) built in (Items 2, 8, 11, 14, 17 and 27; the minimum necessary for endorsement is five plus criterion A[a-c]). Again, MDD symptom criterion A(a-c) (Item 27) requires that the "symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."

Results of the CVSI-V1 Question 1 MDD items Cronbach alpha score for the case of Jeff were high at 0.794. The only items, which if deleted would have increased the Cronbach alpha score were Item 8 (Criterion A[a3]: Significant weight loss when not dieting or weight gain [e.g., a change of more than 5% of body weight in a month], or decrease or increase in appetite nearly every day [during the same 2-week period and representing a change from previous functioning]) and Item 26 (A[a9]: Recurrent thoughts of death [not just fear of dying], recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide [during the same 2-week period and representing a change from previous functioning]), however, they would each only have increased the Cronbach alpha score by, respectively, 0.015 and 0.038 to 0.809 and 0.832, respectively, which were deemed not significant enough increases to warrant either deletion.

For Question 1 in the case of Jeff, pilot participants gave a mean Likert rating for Item 2 (Criterion A[a1]: Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others [during the same 2-week period and representing a change from previous functioning]) of

3.08 (*SD* = 1.17), and for Item 5 (Criterion A[a2]: Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others [during the same 2-week period and representing a change from previous functioning]) the mean Likert rating was 2.33 (*SD* = 1.23), indicating that Item 2 (i.e., MDD symptom criterion) met the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Jeff, but that Item 5 did not. Item 8 (Criterion A[a3]: Significant weight loss when not dieting or weight gain [e.g., a change of more than 5% of body weight in a month], or decrease or increase in appetite nearly every day [during the same 2-week period and representing a change from previous functioning]) showed a mean Likert rating by pilot participants of 3.58 (*SD* = 0.52), and the Item 11 (Criterion A[a4]: Insomnia or hypersomnia nearly every day [during the same 2-week period and representing a change from previous functioning]) mean Likert rating was 3.75 (*SD* = 0.62). The mean Likert rating endorsed by pilot participants for Item 14 (Criterion A[a5]: Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down [during the same 2-week period and representing a change from previous functioning]) was 3.00 (*SD* = 1.04), and for Item 17 (Criterion A[a6]: Fatigue or loss of energy nearly every day [during the same 2-week period and representing a change from previous functioning]) the mean Likert rating was 3.25 (*SD* = 0.87). Item 20 (Criterion A[a7]: Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly

every day, not merely self-reproach or guilt about being sick [during the same 2-week period and representing a change from previous functioning]) had a mean Likert rating among pilot participants of 3.00 (*SD* = 0.95). The mean Likert rating endorsed among pilot participants for Item 23 (Criterion A[a8]: Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others [during the same 2-week period and representing a change from previous functioning]) was 3.25 (*SD* = 0.75), and for Item 26 (Criterion A[a9]: Recurrent thoughts of death [not just fear of dying], recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide [during the same 2-week period and representing a change from previous functioning]) the mean Likert rating was 1.25 (*SD* = 1.14). The mean Likert rating for Item 27 (Criterion A[a-c]: Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure [during the same 2-week period and representing a change from previous functioning]) was 3.67 (*SD* = 0.65) among pilot participants.

Using MDD Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean MDD Subscale score across pilot participants for the case of Jeff (case 3) was 26.58 (*SD* = 12.95), the median was 30.50, and the mode was 0. CVSI-V1 Question 1 MDD Subscale scores for the case of Jeff ranged from 0 to 38. CVSI-V1 MDD Subscale ranges from 0 (10 items at a Likert rating of "0" each) to 40 (10 items at a Likert rating of "4"), and for the case of Jeff the actual built in signal strength (i.e., MDD Subscale score that represents the actual

number of MDD symptom criteria built in to the case by design) equals 18 (six items at a minimum Likert rating of "3"). As indicated earlier in this chapter, the minimum MDD Subscale score that indicates an endorsement by participants of the perception of MDD in a case is 18 (five items plus Item 27 at a minimum Likert rating of "3"). Skewness of the CVSI-V1 Question 1 MDD Subscale scores for the case of Jeff equaled -1.688 (standard error of skewness = 0.637), and Fisher's measure of skewness for the same was calculated to be -2.650. Kurtosis of the CVSI-V1 Question 1 MDD Subscale scores in response to the case of Jeff equaled 1.782 (standard error of kurtosis = 1.232), and Fisher's measure of kurtosis for the same was calculated to be 1.446.

OCD items for Sophie. For Question 1 of the CVSI-V1 case 1, 18 pilot participants completed the 10 OCD sub-items. OCD sub-items included Items 3, 6, 9, 12, 15, 18, 21, 24 which corresponded to OCD criteria A(Obs1), A(Obs2), A(Obs3), A(Obs4), A(Com1), A(Com2), B, and C, respectively (see Appendix L). As indicated earlier, the OCD sub-items are divided into two distinct subscales; the OCD-Obsessions subscale is composed of Items 3, 6, 9, 12, 21 and 24, and the OCD-Compulsions subscale is composed of Items 15, 18, 21 and 24. As indicated earlier in this chapter, case 1 of the CVSI-V1 was that of Sophie and the case was designed to reflect an endorsement of OCD-Compulsions, but not OCD-Obsessions. The case of Sophie was designed with four OCD symptom criteria built in (Items 15, 18, 21 and 24; the minimum necessary for endorsement of OCD with Compulsions is two of compulsions criteria plus criterion B and C). OCD symptom criteria B and C (Items 21 and 24) require that "at some point

during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable" and that "the obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships," respectively.

Results of the CVSI-V1 Question 1 Cronbach alpha score for all OCD items for the case of Sophie were low at 0.469. There were no items which if deleted would increase the Cronbach alpha score for OCD as a whole (i.e., all 10 items). Results of the CVSI-V1 Question 1 Cronbach alpha score for OCD-Obsessions subscale items for the case of Sophie were also low at 0.411. The only item, which if deleted would have increased the Cronbach alpha score for OCD-Obsessions subscale was Item 21 (Criterion B: Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder), and it would only have increased the Cronbach alpha score by 0.001 to 0.412, which was deemed not significant enough to warrant its deletion. Results of the CVSI-V1 Question 1 Cronbach alpha score for OCD-Compulsions subscale items for the case of Sophie were very low at 0.095.

Each item in OCD-Compulsions subscale, if individually deleted, would have resulted in a significant increase in the Cronbach alpha score. Had Item 15 (Criterion A[Com1]: Feeling driven to perform repetitive behaviours or mental acts in response to an obsession, or according to rules that must be applied rigidly) been deleted it would have increased the Cronbach alpha score for the OCD-Compulsions subscale to 0.119. If Item 18 (Criterion A[Com2]: Driven and

repetitive behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive, but are nevertheless aimed at preventing or reducing distress or preventing some dreaded event or situation) had been deleted it would have changed the Cronbach alpha score to -0.322, which is in violation of reliability assumptions but a check of the coding revealed no inaccuracies or problems. Had Item 21 (Criterion B: Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder) been deleted the Cronbach alpha score for the OCD-Compulsions subscale would have increased to 0.447, and had Item 24 (Criterion C: The obsessions or compulsions cause marked distress, are time consuming [take more than 1 hour a day], or significantly interfere with the person's normal routine, occupational [or academic] functioning, or usual social activities or relationships) been deleted the Cronbach alpha score would have changed to -0.126, which is again in violation of reliability assumptions but when coding was checked no inaccuracies were revealed.

For Question 1 in the case of Sophie, pilot participants gave a mean Likert rating for Item 3 (Criterion A[Obs1]: Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress) of 3.33 (*SD* = 0.69), and for Item 6 (Criterion A[Obs2]: The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems) the mean Likert rating was 2.78 (*SD* = 0.94), indicating that Item 3 (i.e., OCD symptom criterion) met the threshold (a Likert rating of 3) for

perception by pilot participants to be contributing to the overall presenting problem in the case of Sophie, but Item 6 did not. Item 9 (Criterion A[Obs3]: Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action) showed a mean Likert rating by pilot participants of 2.67 (*SD* = 1.19), and the Item 12 (Criterion A[Obs4]: Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind [not imposed from without as in thought insertion]) mean Likert rating was 1.83 (*SD* = 1.30). The mean Likert rating endorsed by pilot participants for Item 15 (Criterion A[Com1]: Feeling driven to perform repetitive behaviours or mental acts in response to an obsession, or according to rules that must be applied rigidly) was 2.17 (*SD* = 1.30), and for Item 18 (Criterion A[Com2]: Driven and repetitive behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive, but are nevertheless aimed at preventing or reducing distress or preventing some dreaded event or situation) the mean Likert rating was 2.50 (*SD* = 1.10). Item 21 (Criterion B: Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder) had a mean Likert rating among pilot participants of 2.61 (*SD* = 1.20), and for Item 24 (Criterion C: The obsessions or compulsions cause marked distress, are time consuming [take more than 1 hour a day], or significantly interfere with the person's normal routine, occupational [or academic] functioning, or usual social activities or relationships) the mean Likert

rating among pilot participants was 3.61 (*SD* = 0.70).

Using OCD Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean OCD-Obsessions Subscale score across pilot participants for the case of Sophie (case 1) was 10.94 (*SD* = 9.21), the median was 15.5, and the mode was 0. The CVSI-V1 Question 1 OCD-Obsessions Subscale scores for the case of Sophie ranged from 0 to 22. CVSI-V1 Question 1 mean OCD-Compulsions Subscale score across pilot participants for the case of Sophie (case 1) was 7.11 (*SD* = 6.15), the median was 9, and the mode was 0. CVSI-V1 Question 1 OCD-Compulsions Subscale scores for the case of Sophie ranged from 0 to 15. Skewness of the CVSI-V1 Question 1 OCD-Obsessions Subscale scores for the case of Sophie equaled -0.334 (standard error of skewness = 0.536), and Fisher's measure of skewness for the same was calculated to be -0.623. Kurtosis of the CVSI-V1 Question 1 OCD-Obsessions Subscale scores in response to the case of Sophie equaled -1.884 (standard error of kurtosis = 1.038), and Fisher's measure of kurtosis for the same was calculated to be -1.815. Skewness of the CVSI-V1 Question 1 OCD-Compulsions Subscale scores for the case of Sophie equaled -0.180 (standard error of skewness = 0.536), and Fisher's measure of skewness for the same was calculated to be -0.335. Kurtosis of the CVSI-V1 Question 1 OCD-Compulsions Subscale scores in response to the case of Sophie equaled -1.806 (standard error of kurtosis = 1.038), and Fisher's measure of kurtosis for the same was calculated to be -1.739.

It should be noted that the CVSI-V1 OCD-Obsessions Subscale ranges from 0 (six items at a Likert rating of "0" each) to 24 (six items at a Likert rating

of “4”) and the OCD-Compulsions Subscale ranges from 0 (four items at a Likert rating of “0” each) to 16 (four items at a Likert rating of “4”). For the case of Sophie the actual built in signal strength (i.e., OCD-Obsessions and OCD-Compulsions Subscale scores that represents the actual number of OCD symptom criteria built in to the case by design) equals 6 for OCD-Obsessions (two items at a minimum Likert rating of “3”) and 12 for OCD-Compulsions (four items at a minimum Likert rating of “3”). As indicated earlier in this chapter, the minimum OCD-Obsessions Subscale score that indicates an endorsement by participants of the perception of OCD with Obsessions in a case is 18 (four items plus Items 21 and 24 at a minimum Likert rating of “3”). The minimum OCD-Compulsions Subscale score that indicates endorsement by participants of the perception of OCD with Compulsions in a case is 12 (two items plus Items 21 and 24 at a minimum Likert rating of “3”).

OCD items for Bill. For Question 1 of the CVSI-V1 case 2, 14 pilot participants completed the 10 OCD sub-items. Case 2 of the CVSI-V1 was that of Bill and the case was designed to reflect neither an endorsement of OCD-Compulsions nor OCD-Obsessions. The case of Bill was designed with five OCD symptom criteria built in (Items 9, 12, 15, 21 and 24; the minimum necessary for endorsement of OCD with Obsessions is four of obsessions criteria plus criterion B and C, and for OCD with Compulsions is two of compulsions criteria plus criterion B and C).

Results of the CVSI-V1 Question 1 Cronbach alpha score for all OCD items for the case of Bill were moderate at 0.672. The only items, which if

deleted would have increased the Cronbach alpha score for OCD as a whole (i.e., all 10 items) were Item 9 (Criterion A[Obs3]: Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action) and Item 21 (Criterion B: Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder), however, they would each have only increased the Cronbach alpha score respectively by 0.01 and 0.006, respectively, which were not deemed significant enough increases to warrant the deletion of either item. Results of the CVSI-V1 Question 1 Cronbach alpha score for OCD-Obsessions subscale items for the case of Bill were low at 0.570. The only item, which if deleted would have increased the Cronbach alpha score for OCD-Obsessions subscale was Item 12 (Criterion A[Obs4]: Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind [not imposed from without as in thought insertion]), and it would have increased the Cronbach alpha score by 0.124 to 0.694, which while significant enough to warrant its deletion, would have rendered the construct of OCD with Obsessions questionable and no longer an accurate reflection of that contained in the DSM-IV-TR (APA, 2000) and so Item 12 was retained. Results of the CVSI-V1 Question 1 Cronbach alpha score for OCD-Compulsions subscale items for the case of Bill were also low at 0.537. Again, the only item, which if deleted would have increased the Cronbach alpha score for OCD-Compulsions subscale was Item 21 (Criterion B: Recognizes that the obsessions or compulsions are

excessive or unreasonable at some point during the course of his/her disorder), and while it would have increased the Cronbach alpha score significantly by 0.121 to 0.658, again concerns about rendering the construct of OCD with Compulsions questionable and inaccurate as per the DSM-IV-TR (APA, 2000) resulted in Item 21 being retained.

For Question 1 in the case of Bill, pilot participants gave a mean Likert rating for Item 3 (Criterion A[Obs1]: Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress) of 3.36 (*SD* = 0.93), and for Item 6 (Criterion A[Obs2]: The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems) the mean Likert rating was 3.29 (*SD* = 0.91), indicating that both Item 3 and Item 6 (i.e., OCD symptom criteria) met the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Bill. Item 9 (Criterion A[Obs3]: Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action) showed a mean Likert rating by pilot participants of 2.86 (*SD* = 1.35), and the Item 12 (Criterion A[Obs4]: Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind [not imposed from without as in thought insertion]) mean Likert rating was 2.14 (*SD* = 1.51). The mean Likert rating endorsed by pilot participants for Item 15 (Criterion A[Com1]: Feeling driven to perform repetitive

behaviours or mental acts in response to an obsession, or according to rules that must be applied rigidly) was 3.50 (*SD* = 1.16), and for Item 18 (Criterion A[Com2]: Driven and repetitive behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive, but are nevertheless aimed at preventing or reducing distress or preventing some dreaded event or situation) the mean Likert rating was 2.50 (*SD* = 1.40). Item 21 (Criterion B: Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder) had a mean Likert rating among pilot participants of 2.93 (*SD* = 0.73), and for Item 24 (Criterion C: The obsessions or compulsions cause marked distress, are time consuming [take more than 1 hour a day], or significantly interfere with the person's normal routine, occupational [or academic] functioning, or usual social activities or relationships) the mean Likert rating among pilot participants was 3.79 (*SD* = 0.58).

Using OCD Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean OCD-Obsessions Subscale score across pilot participants for the case of Bill (case 2) was 13.50 (*SD* = 9.32), the median was 16, and the mode was 0. The CVSI-V1 Question 1 OCD-Obsessions Subscale scores for the case of Bill ranged from 0 to 24. The CVSI-V1 Question 1 mean OCD-Compulsions Subscale score across pilot participants for the case of Bill (case 2) was 9.43 (*SD* = 6.58), the median was 12, and the mode was 0. CVSI-V1 Question 1 OCD-Compulsions Subscale scores for the case of Bill ranged from 0 to 16. Skewness of the CVSI-V1 Question 1 OCD-Obsessions Subscale scores for the case of Bill

equaled -0.730 (standard error of skewness = 0.597), and Fisher's measure of skewness for the same was calculated to be -1.22. Kurtosis of the CVSI-V1 Question 1 OCD-Obsessions Subscale scores in response to the case of Bill equaled -1.232 (standard error of kurtosis = 1.154), and Fisher's measure of kurtosis for the same was calculated to be -1.067. Skewness of the CVSI-V1 Question 1 OCD-Compulsions Subscale scores for the case of Bill equaled -0.692 (standard error of skewness = 0.597), and Fisher's measure of skewness for the same was calculated to be -1.159. Kurtosis of the CVSI-V1 Question 1 OCD-Compulsions Subscale scores in response to the case of Bill equaled -1.345 (standard error of kurtosis = 1.154), and Fisher's measure of kurtosis for the same was calculated to be -1.165.

Again, please note that the CVSI-V1 OCD-Obsessions Subscale ranges from 0 (six items at a Likert rating of "0" each) to 24 (six items at a Likert rating of "4") and the OCD-Compulsions Subscale ranges from 0 (four items at a Likert rating of "0" each) to 16 (four items at a Likert rating of "4"). For the case of Bill the actual built in signal strength (i.e., OCD-Obsessions and OCD-Compulsions Subscale scores that represents the actual number of OCD symptom criteria built in to the case by design) equals 12 for OCD-Obsessions (four items at a minimum Likert rating of "3") and 9 for OCD-Compulsions (three items at a minimum Likert rating of "3"). As indicated earlier in this chapter, the minimum OCD-Obsessions Subscale score that indicates an endorsement by participants of the perception of OCD with Obsessions in a case is 18 (four items plus Items 21 and 24 at a minimum Likert rating of "3"). The minimum OCD-Compulsions

Subscale score that indicates endorsement by participants of the perception of OCD with Compulsions in a case is 12 (two items plus Items 21 and 24 at a minimum Likert rating of "3").

OCD items for Jeff. For Question 1 of the CVSI-V1 case 3, 12 pilot participants completed the 10 OCD sub-items. Case 3 of the CVSI-V1 was that of Jeff and the case was designed to reflect neither an endorsement of OCD-Compulsions nor OCD-Obsessions. The case of Jeff was designed with three OCD symptom criteria built in (Items 3, 9, and 12; the minimum necessary for endorsement of OCD with Obsessions is four of obsessions criteria plus criterion B and C, and for OCD with Compulsions is two of compulsions criteria plus criterion B and C).

Results of the CVSI-V1 Question 1 Cronbach alpha score for all OCD items for the case of Jeff were moderate at 0.735. The only items, which if deleted would have increased the Cronbach alpha score for OCD as a whole (i.e., all 10 items) were Item 18 (Criterion A[Com2]: Driven and repetitive behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive, but are nevertheless aimed at preventing or reducing distress or preventing some dreaded event or situation) and Item 24 (Criterion C: The obsessions or compulsions cause marked distress, are time consuming [take more than 1 hour a day], or significantly interfere with the person's normal routine, occupational [or academic] functioning, or usual social activities or relationships), however, they would each have only increased the Cronbach alpha score by 0.044 and 0.018, respectively, which were not deemed

significant enough increases to warrant the deletion of either item. Results of the CVSI-V1 Question 1 Cronbach alpha score for OCD-Obsessions subscale items for the case of Jeff were high at 0.772. The only item, which if deleted would have increased the Cronbach alpha score for OCD-Obsessions subscale was Item 24 (Criterion C: The obsessions or compulsions cause marked distress, are time consuming [take more than 1 hour a day], or significantly interfere with the person's normal routine, occupational [or academic] functioning, or usual social activities or relationships), and it would have increased the Cronbach alpha score by 0.061 to 0.833, which was not deemed significant enough to warrant its deletion. Results of the CVSI-V1 Question 1 Cronbach alpha score for OCD-Compulsions subscale items for the case of Jeff were low at 0.354. No items were identified, which if deleted would have increased the Cronbach alpha score for OCD-Compulsions subscale for the case of Jeff.

For Question 1 in the case of Jeff, pilot participants gave a mean Likert rating for Item 3 (Criterion A[Obs1]: Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress) of 2.67 (*SD* = 1.61), and for Item 6 (Criterion A[Obs2]: The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems) the mean Likert rating was 2.83 (*SD* = 1.03), indicating that neither Item 3 nor Item 6 (i.e., OCD symptom criteria) met the threshold (a Likert rating of 3) for perception by pilot participants to be contributing to the overall presenting problem in the case of Jeff. Item 9 (Criterion A[Obs3]: Attempts made

to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action) showed a mean Likert rating by pilot participants of 2.58 (*SD* = 1.17), and the Item 12 (Criterion A[Obs4]: Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind [not imposed from without as in thought insertion]) mean Likert rating was 2.50 (*SD* = 1.00). The mean Likert rating endorsed by pilot participants for Item 15 (Criterion A[Com1]: Feeling driven to perform repetitive behaviours or mental acts in response to an obsession, or according to rules that must be applied rigidly) was 2.08 (*SD* = 1.51), and for Item 18 (Criterion A[Com2]: Driven and repetitive behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive, but are nevertheless aimed at preventing or reducing distress or preventing some dreaded event or situation) the mean Likert rating was 2.50 (*SD* = 1.09). Item 21 (Criterion B: Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder) had a mean Likert rating among pilot participants of 1.92 (*SD* = 1.38), and for Item 24 (Criterion C: The obsessions or compulsions cause marked distress, are time consuming [take more than 1 hour a day], or significantly interfere with the person's normal routine, occupational [or academic] functioning, or usual social activities or relationships) the mean Likert rating among pilot participants was 2.83 (*SD* = 1.12).

Using OCD Subscale Scoring Protocol (see Appendix H), the CVSI-V1 Question 1 mean OCD-Obsessions Subscale score across pilot participants for the case of Jeff (case 3) was 5.50 (*SD* = 10.01), the median was 0, and the mode was 0. The CVSI-V1 Question 1 OCD-Obsessions Subscale scores for the case of Jeff ranged from 0 to 24. The CVSI-V1 Question 1 mean OCD-Compulsions Subscale score across pilot participants for the case of Jeff (case 3) was 3.17 (*SD* = 5.83), the median was 0, and the mode was 0. CVSI-V1 Question 1 OCD-Compulsions Subscale scores for the case of Jeff ranged from 0 to 16. Skewness of the CVSI-V1 Question 1 OCD-Obsessions Subscale scores for the case of Jeff equaled 1.375 (standard error of skewness = 0.637), and Fisher's measure of skewness for the same was calculated to be 2.158. Kurtosis of the CVSI-V1 Question 1 OCD-Obsessions Subscale scores in response to the case of Jeff equaled -0.078 (standard error of kurtosis = 1.232), and Fisher's measure of kurtosis for the same was calculated to be -0.063. Skewness of the CVSI-V1 Question 1 OCD-Compulsions Subscale scores for the case of Jeff equaled 1.455 (standard error of skewness = 0.637), and Fisher's measure of skewness for the same was calculated to be 2.284. Kurtosis of the CVSI-V1 Question 1 OCD-Compulsions Subscale scores in response to the case of Jeff equaled 0.342 (standard error of kurtosis = 1.232), and Fisher's measure of kurtosis for the same was calculated to be 0.277.

Again, the CVSI-V1 OCD-Obsessions Subscale ranges from 0 (six items at a Likert rating of "0" each) to 24 (six items at a Likert rating of "4") and the OCD-Compulsions Subscale ranges from 0 (four items at a Likert rating of "0"

each) to 16 (four items at a Likert rating of “4”). For the case of Jeff the actual built in signal strength (i.e., OCD-Obsessions and OCD-Compulsions Subscale scores that represents the actual number of OCD symptom criteria built in to the case by design) equals 9 for OCD-Obsessions (three items at a minimum Likert rating of “3”) and 0 for OCD-Compulsions (0 items at a minimum Likert rating of “3”). As indicated earlier in this chapter, the minimum OCD-Obsessions Subscale score that indicates an endorsement by participants of the perception of OCD with Obsessions in a case is 18 (four items plus Items 21 and 24 at a minimum Likert rating of “3”). The minimum OCD-Compulsions Subscale score that indicates endorsement by participants of the perception of OCD with Compulsions in a case is 12 (two items plus Items 21 and 24 at a minimum Likert rating of “3”).

CVSI-V1 Question 2. Question 2 of CVSI-V1 focused on measuring which of 29 listed possible presenting problems participants identified were in need of therapeutic attention in each of the three fictional case vignettes. Participants were asked to select the top five presenting problems they believed were illustrated in the immediately preceding case and to rate them each from 1 to 5, with a rating of 1 meaning they believed the problem to be the primary problem in need of therapeutic attention, and a rating of 5 meaning they believed the problem to be the most peripheral problem in need of therapeutic attention. Problems not selected among the top five were given a rating of 0, meaning that the problem was not believed by the participant to be a presenting problem in need of therapeutic attention in the preceding case. Of interest statistically are

those categories believed to be the primary problem in need of therapeutic attention (a Likert rating of 1).

Of focus for this study was the technically accurate presenting problem category of Cybersex Addiction (Sub-item #19) and, in an effort to be more clinically relevant, the presenting problem category of Sex Addiction (Sub-item #18) was subsequently grouped with it. Of secondary focus for this study were the categories of MDD-Single Episode (MDD-SE; Sub-item #4), MDD-Recurrent Episodes (MDD-RE; Sub-item #5), and OCD (Sub-item #11). All other 24 categories listed were provided as a means of distracting attention away from the above two main categories of interest (CSA and SA) and three secondary ones (MDD-SE, MDD-RE, and OCD); however, results involving them are grouped as "Other" and provided here (at the grouped and individual level) for descriptive purposes only.

CSA and SA categories for Sophie. For CVSI-V1 case 1, 18 pilot participants completed Question 2. As indicated earlier in this chapter, case 1 of the CVSI-V1 was that of Sophie and the case was designed to reflect an endorsement of CSA. Results of a chi-square test for goodness of fit showed there was no significant difference in proportion between those participants who thought that Sophie's primary problem in need of therapeutic attention was Cybersex Addiction (27.8%, $n = 5$), as compared to those who thought it was something else other than Cybersex Addiction (72.2%, $n = 13$), χ^2 (1, $n = 18$) = 3.56, $p > .05$. This result indicates that the majority of pilot participants were not able to accurately identify CSA as the primary presenting problem in the case of

Sophie. When Cybersex Addiction was grouped with Sex Addiction, results of a chi-square test for goodness of fit showed there was no significant difference between the proportion of those participants who thought that Sophie's primary problem in need of therapeutic attention was either Cybersex Addiction or Sex Addiction (55.55%, $n = 10$), as compared to those who thought it was neither Cybersex Addiction nor Sex Addiction (44.45%, $n = 8$), χ^2 (1, $n = 18$) = 0.22, $p > .10$. This subsequent result indicates that slightly more pilot participants were able to accurately identify the primary presenting problem in the case of Sophie as being either CSA or SA when these two categories were grouped. Information about the percentage of pilot participants who gave CSA and SA Likert ratings of 2 through 5 in response to the case of Sophie can be found in Appendix U.

CSA and SA categories for Bill. Fourteen pilot participants completed Question 2 of the CVSI-V1 case 2. As indicated earlier in this chapter, case 2 of the CVSI-V1 was that of Bill and the case was designed to reflect an endorsement of CSA. Results of a chi-square test for goodness of fit showed there was no significant difference between the proportion of those participants who thought that Bill's primary problem in need of therapeutic attention was Cybersex Addiction (42.9%, $n = 6$), as compared to those who thought it was something else other than Cybersex Addiction (57.1%, $n = 8$), χ^2 (1, $n = 14$) = 0.29, $p > .10$. This result indicates that the majority of pilot participants were not able to accurately identify CSA as the primary presenting problem in the case of Bill. When Cybersex Addiction was grouped with Sex Addiction, results of a chi-square test for goodness of fit showed there was no significant difference between

the proportion of those participants who thought that Bill's primary problem in need of therapeutic attention was either Cybersex Addiction or Sex Addiction (57.1%, $n = 8$), as compared to those who thought it was neither Cybersex Addiction nor Sex Addiction (42.9%, $n = 6$), χ^2 (1, $n = 14$) = 0.29, $p > .10$. This subsequent result indicates that the majority of pilot participants were able to accurately identify the primary presenting problem in the case of Bill as being either CSA or SA when these two categories were grouped. Information about the percentage of pilot participants who gave CSA and SA Likert ratings of 2 through 5 in response to the case of Bill can be found in Appendix U.

CSA and SA categories for Jeff. Twelve pilot participants completed Question 2 of the CVSI-V1 case 3. As indicated earlier in this chapter, case 3 of the CVSI-V1 was that of Jeff and the case was designed to reflect no endorsement of CSA. A chi-square test for goodness of fit could not be conducted because there were no cases in one of the two groups compared; therefore a Binomial Test at 50% probability was conducted instead. Results of a Binomial Test at 50% probability showed a significant difference between the proportion of those participants who thought that Jeff's primary problem in need of therapeutic attention was Cybersex Addiction (0%, $n = 0$), as compared to those who thought it was something else other than Cybersex Addiction (100%, $n = 12$), $p < .001$. Range for the subsequently calculated[6] 95% Confidence Interval (C.I.) did not span "0" (range +0.22, +0.78) thus supporting this significant Binomial Test

[6] The 95% Confidence Interval for the Binomial Test at 50% probability was calculated using the formula C.I. = P +/- $(z)(Sp)$, where Sp = *the square root of* $[(P)(Q)]/n$, and where $n = 12$, $P = 0.5$, $Q = 0.5$, and $z = 1.96$.

finding for the case of Jeff. This result indicates that a significant majority of pilot participants were able to accurately identify that CSA was not the primary presenting problem in the case of Jeff. When Cybersex Addiction was grouped with Sex Addiction, results of a chi-square test for goodness of fit showed no significant difference between the proportion of those participants who thought that Jeff's primary problem in need of therapeutic attention was either Cybersex Addiction or Sex Addiction (33.33%, $n = 4$), as compared to those who thought it was neither Cybersex Addiction nor Sex Addiction (66.66%, $n = 8$), χ^2 (1, $n = 12$) = 1.33, $p > .10$. This subsequent result indicates that the majority of pilot participants were able to accurately identify the primary presenting problem in the case of Jeff as being neither CSA nor SA when these two categories were grouped. Information about the percentage of pilot participants who gave CSA and SA Likert ratings of 2 through 5 in response to the case of Jeff can be found in Appendix U.

MDD and OCD categories for Sophie. As indicated earlier, case 1 of the CVSI-V1 was that of Sophie and the case was designed to not reflect an endorsement of MDD. Results of a chi-square test for goodness of fit showed there was no significant difference between those participants who thought that Sophie's primary problem in need of therapeutic attention was either MDD-SE or MDD-RE (27.8%, $n = 5$), as compared to those who thought it was neither MDD-SE nor MDD-RE (72.2%, $n = 13$), χ^2 (1, $n = 18$) = 3.56, $p > .05$. This finding indicates that the majority of pilot participants identified that MDD was not the primary presenting problem in the case of Sophie.

The case of Sophie was designed to reflect an endorsement of OCD. A chi-square test for goodness of fit could not be conducted because there were no cases in one of the two groups compared; therefore a Binomial Test at 50% probability was conducted instead. Results of a Binomial Test at 50% probability showed a significant difference between those participants who thought that Sophie's primary problem in need of therapeutic attention was OCD (0%, $n = 0$), as compared to those who thought it was not OCD (100%, $n = 18$), $p < .001$. Range for the subsequently calculated 95% Confidence Interval (C.I.) did not span "0" (range +0.27, +0.73) thus supporting this significant Binomial Test finding for the case of Sophie. This finding indicates that a significant majority of pilot participants identified that OCD was not the primary presenting problem in the case of Sophie. Information about the percentage of pilot participants who gave the categories of MDD-SE, MDD-RE, and OCD Likert ratings of 2 through 5 in response to the case of Sophie can be found in Appendix U.

MDD and OCD categories for Bill. As indicated earlier, case 2 of the CVSI-V1 was that of Bill and the case was designed to not reflect an endorsement of MDD. Results of a chi-square test for goodness of fit showed there was no significant difference between those participants who thought that Bill's primary problem in need of therapeutic attention was either MDD-SE or MDD-RE (28.6%, $n = 4$), as compared to those who thought it was neither MDD-SE nor MDD-RE (71.4%, $n = 10$), χ^2 (1, $n = 14$) = 2.57, $p > .10$. This finding indicates that the majority of pilot participants identified that MDD was not the primary presenting problem in the case of Bill.

The case of Bill was designed to not reflect an endorsement of OCD. Results of a chi-square test for goodness of fit showed a significant difference between those participants who thought that Bill's primary problem in need of therapeutic attention was OCD (14.3%, $n = 2$), as compared to those who thought it was not OCD (85.7%, $n = 12$), χ^2 (1, $n = 14$) = 7.14, $p < .01$. This finding indicates that a significant majority of pilot participants identified that OCD was not the primary presenting problem in the case of Bill. Information about the percentage of pilot participants who gave the categories of MDD-SE, MDD-RE, and OCD Likert ratings of 2 through 5 in response to the case of Bill can be found in Appendix U.

MDD and OCD categories for Jeff. As indicated earlier, case 3 of the CVSI-V1 was that of Jeff and the case was designed to reflect an endorsement of MDD. Results of a chi-square test for goodness of fit showed there was a significant difference between those participants who thought that Jeff's primary problem in need of therapeutic attention was either MDD-SE or MDD-RE (16.7%, $n = 2$), as compared to those who thought it was neither MDD-SE nor MDD-RE (83.3%, $n = 10$), χ^2 (1, $n = 12$) = 5.33, $p < .05$. This finding indicates that the majority of pilot participants identified that MDD was not the primary presenting problem in the case of Jeff.

The case of Jeff was designed to not reflect an endorsement of OCD. Results of a chi-square test for goodness of fit showed a significant difference between those participants who thought that Jeff's primary problem in need of therapeutic attention was OCD (8.3%, $n = 1$), as compared to those who thought it

was not OCD (91.7%, $n = 11$), χ^2 (1, $n = 12$) = 8.33, $p < .01$. This finding indicates that a significant majority of pilot participants identified that OCD was not the primary presenting problem in the case of Jeff. Information about the percentage of pilot participants who gave the categories of MDD-SE, MDD-RE, and OCD Likert ratings of 2 through 5 in response to the case of Jeff can be found in Appendix U.

CVSI expert validation. As indicated earlier, EV1 and EV3 provided quantitative feedback on the pilot versions of the CVSI, while EV1, EV2 and EV3 provided qualitative feedback. The CVSI-V1 was reviewed by EV1 and EV2, and the CVSI-V2 (Appendix V) was reviewed only by EV3. Also, as indicated earlier, only the CVSI was administered to the Expert Validators, not the demographic or SOS-R-M measures.

Quantitative. In response to the case of Sophie, EV1 and EV3 scored a 25 and 22 on the CSA Subscale, respectively (see Appendix W for summary of quantitative feedback from EVs). As indicated earlier, a minimum endorsement of CSA is indicated by a score of 9, and a CSA Subscale score of 12 is an accurate reflection of the precise number of CSA symptom criteria built into the case of Sophie. Both EV1 and EV3, therefore, were able to accurately perceive the presence of CSA in the case of Sophie, although both appeared to over-perceive the number of symptom criteria actually built into the case. In response to identifying the category that reflects the primary presenting problem in need of therapeutic attention in the case of Sophie, only EV1 selected CSA, and both EV1 and EV3 selected SA.

In response to the case of Bill, EV1 and EV3 scored a 23 and 28 on the CSA Subscale, respectively. A CSA Subscale score of 21 is an accurate reflection of the precise number of CSA symptom criteria built into the case of Bill. Both EV1 and EV3, therefore, were able to accurately perceive the presence of CSA in the case of Bill, although both appeared to slightly over-perceive the number of symptom criteria actually built into the case. In response to identifying the category that reflects the primary presenting problem in need of therapeutic attention in the case of Bill, EV1 selected SA while EV3 selected CSA.

Finally, in response to the case of Jeff, EV1 and EV3 scored a 5 and 19 on the CSA Subscale, respectively. In the case of Jeff, a CSA Subscale score of 6 is an accurate reflection of the precise number of CSA symptom criteria built in. EV1, therefore, appeared able to accurately perceive the lack of CSA in the case of Jeff, however, EV3 appeared unable to do so and inaccurately over-perceived the number of CSA symptom criteria actually built into the case. In response to identifying the category that reflects the primary presenting problem in need of therapeutic attention in the case of Jeff, both Expert Validators selected incorrectly with EV1 selecting SA and EV3 selecting CSA.

Qualitative. The details involved in the qualitative feedback provided by the Expert Validators can be found in Appendix X. In general the qualitative feedback includes a general validation of the construct of the cases and the questions following them, a recommendation to reduce the number of question sub-items, and a tendency towards inaccurately perceiving CSA in the case of Jeff. A note is warranted with regards to the latter piece of feedback. The process

of recruiting Expert Validators involved disclosing the true purpose of this research study. The necessity of full disclosure regarding the purpose of the study may therefore have biased the Expert Validators towards perceiving CSA in all three of the cases, including that of Jeff. Revisions were subsequently made to the construct of the case vignettes and the length of the CVSI in response to data collected from the pilot participants and the Expert Validators.

Revisions.

After CVSI-V1. Revisions were made to the CVSI-V1 based on the data collected from the pilot participants, EV1 and EV2. Revisions made to the CVSI-V1 included first reorganizing the order of the case vignettes 1 to 3 from Sophie/Bill/Jeff (i.e., medium/high/low CSA signal strength built in) to Jeff/Sophie/Bill (i.e., low/medium/high CSA signal strength built in) in the CVSI-V2. Case reorganization was done to allow for greater control in manipulating and assessing for the effect of case order on participants responses to the questions therein.

Second, the number of MDD and OCD symptom criteria built into each case vignette was maximized so that each case vignette reflected a diagnosis of MDD as well as OCD with Obsessions and Compulsions. Symptom maximization for MDD and OCD was done to reduce the diagnostic variation between the cases to only that which involved CSA criteria, thereby allowing for a simpler and more straightforward statistical analysis and interpretation.

Third, the number of sub-items in Question 1 of the CVSI-V1 was reduced from 27 to 18 by removing selected OCD and MDD symptom criteria related

items. A reduction of Question 1 sub-items was done to decrease the length and as a result the total amount of time taken to complete the measure, which it was hoped would result in a decreased participant fatigue and attrition.

Finally, in the CVSI-V2 the order of Question 1 was switched with Question 2 and vice versa, and each was relabelled as appropriate. Switching the order of Question 1 with Question 2 was done in an attempt to avoid priming participants with the wording of CSA related symptom criteria sub-items in the CVSI-V1 Question 1. Question 1 was also switched with Question 2 in the CVSI-V2 in an attempt to more closely reflect the typical clinical differential diagnosis process. The typical process of differential diagnosis is one in which clinicians develop a mental list of the possible diagnoses that they identify may be implicated in the case of a client (i.e., as per CVSI-V2 Question 1) before subsequently following up with symptom specific questions to rule a certain diagnosis in or out (i.e., as per CVSI-V2 Question 2).

After CVSI-V2. Revisions were made to the CVSI-V2 based on the data collected from EV2 and in light of patterns from the previous data collected in response to the CVSI-V1. Firstly, the number of CSA symptom criteria built into the cases of Jeff and Sophie were reduced by one each. CSA symptom criteria reduction was done in response to what appeared to be an inflated CSA Subscale score in both the case of Jeff and of Sophie, and thus over-perception of CSA symptom criteria, on the part of the pilot participants as well as the Expert Validators. Secondly, an additional version of the CVSI was created in which the order of the case vignettes was reversed (i.e., Jeff/Sophie/Bill as well as

Bill/Sophie/Jeff) so that any case order effects could be statistically analysed.

Finally, the CVSI was moved from the last survey position (after that of the demographic survey and the SOS-R-M) to the first survey position followed by the SOS-R-M and then the demographic survey. Moving the CVSI to the first survey position was done in the hope that participation in Phase II of the study would be increased due to interest captured early on with the CVSI case vignette narratives. It was also hoped that attrition would be reduced due to increased participant investment in the dependent measure (the CVSI) early on and decreased boredom.

CVSI-V3. The final version of the CVSI - the Client Vignette Scoring Instrument Version 3 (CVSI-V3) - was composed of three fictional client case vignettes (Jeff, Sophie, and Bill). Two versions of the CVSI-V3 were created to test for case order effects; one in which the cases were ordered from a low to high number of CSA symptom criteria built in (CVSI-V3a; Jeff/Sophie/Bill) and one in which they were ordered from high to low (CVSI-V3b; Bill/Sophie/Jeff). The client case vignette of Jeff has only one CSA diagnostic criteria built into the design of the case, while that of Sophie has three, and that of Bill has nine CSA diagnostic criteria built in. The minimum number of CSA diagnostic criteria required for a diagnosis of CSA is three.

In addition to the varying number of CSA symptom criteria, each case was also designed to reflect the diagnoses MDD and OCD with the maximum number of each of these diagnostic criteria built into the design of each case.

Two questions follow each client case vignette in the CVSI-V3. Question 1 focuses on asking participants to identify and select the top five presenting problems that they believe are illustrated in the preceding case from a provided list and rank them from 1 (*primary presenting problem in need of therapeutic attention*) to 5 (*most peripheral therapeutic problem in need of therapeutic attention*). Included in the list is the category of Cybersex Addiction as well as that of Sex Addiction. Question 2 invites participants to respond to a series of symptoms using a 5-point Likert rating ranging from 0 (*not at all contributing*) to 4 (*a key contributor*) to indicate the degree to which they believe the symptom to be contributing to the overall presenting problem of the client in the preceding case (Jeff, Sophie, or Bill). There are 18 symptoms listed under Question 2, of which nine represent CSA with the remainder representing some but not all MDD and OCD diagnostic criteria. The CVSI-V3 was consequently used as the dependent measure in Phase II of this study.

Chapter 4 – Phase II: Method

This chapter outlines the method of Phase II of this research, which is the main study designed to address the research questions discussed earlier. The results from Phase II will be described in Chapter 5.

Participants

Outlined below is a general description of the two populations from which, and at the time, the convenience sample for Phase II of this study was selected.

Canadian Psychological Association members. The mandate of the Canadian Psychological Association (CPA) is to make a positive contribution to Canadian health and welfare; to promote the research, education, and practice of psychology; to aid in the development and dissemination of psychology-related knowledge and its applications, and; to serve its members (CPA, 2013a). The CPA is a national voluntary membership organization. Information about CPA members can be found in the CPA Annual report and is limited in scope and detail.

Statistics from 2010[7] indicated a CPA membership total of 6,544, with 64.07% (4,193) of those being Full CPA Members[8] and 26.51% (1,735) being

[7] 2010 is the year in which data was collected for this research study.

[8] A "Full Member" refers to someone who has a graduate (Master's or Doctorate) degree in Psychology (or academic equivalent) given to them by recognized graduate school (CPA, 2013b).

students[9] (CPA, 2012). Honorary Life Fellows and Honorary Life Members[10] numbered 228 (3.48%) in total, and 59 (0.90%) were listed as Retired Fellows or Members (CPA, 2012). Special Affiliate[11] CPA members numbered 90 (1.38%) and those who met International status[12] (including students and non-students) were 51 (0.78%) in total (CPA, 2012). Gender distribution of the overall total CPA members was 34.99% (2,290) male and 65.01% (4,254) female (CPA, 2012); however, this includes all possible categories of membership. The vast majority (92.21%) spoke English as their primary language while the remainder spoke French (CPA, 2012). More detailed and demographics for all CPA members or for each of the individual CPA sections was unfortunately not available.

Psychologists' Association of Alberta members. An anonymous survey distributed via mail in February 2010 to approximately 2,538 registered psychologist members of the Psychologists' Association of Alberta (PAA) yielded

[9] A "Student Affiliate" refers to students enrolled in undergraduate or graduate studies in psychology at a recognized academic institution within Canada or the USA (CPA, 2013b).

[10] "Honorary Life Fellows" and "Honorary Life Members" are those who meet membership criteria and who are greater than or equal to 70 years of age and have maintained "Full Member" status for a minimum of 25 years (CPA, 2013b).

[11] A "Special Affiliate" refers to those who reside in Canada or the USA who are interested in the profession or science of psychology but do not qualify for membership (CPA, 2013b).

[12] "International Affiliates" or "International Student Affiliates" are those who either meet membership qualifications but reside outside North America (Canada and USA), or those who attend undergraduate or graduate studies in psychology outside North America, respectively (CPA, 2013b).

an 18% response rate resulting in 457 respondents (Petrovic-Poljak, Dobson, & Berube, 2010). Of the respondents, 90% were fully registered while 10% were provisionally registered (Petrovic-Poljak et al., 2010). Comparison data from the College of Alberta Psychologists (CAP) indicated at the time that 70% of the CAP members were female, while 30% were male; additionally, 33% of CAP members held doctoral degrees, while 67% held master's degrees (Petrovic-Poljak et al., 2010). Of the PAA member psychologists, 68% were female (32% were male) and 38% held doctoral degrees (62% held master's degrees) (Petrovic-Poljak et al., 2010). The mean length of time for which PAA members reported practicing was 15 years (Petrovic-Poljak et al., 2010).

Forty-one percent of PAA member psychologists were employed in private practice, while 13% worked in schools, 11% were employed in community mental health clinics, 9% worked in hospitals, and 8% were employed in universities and colleges (Petrovic-Poljak et al., 2010). The majority of PAA member psychologists' time was spent in clinical (18%) or counselling (38%) psychology, while 17% spent their time engaged in the practice areas of school psychology, health psychology, teaching, forensic psychology, research, neuropsychology, and industrial/organizational psychology, and 19% described their time spent as mixed between two or more of the above (Petrovic-Poljak et al., 2010). The remaining 7% of PAA member psychologists described their time as being spent primarily in managerial or supervisory roles (Petrovic-Poljak et al., 2010). PAA member psychologists spent more than half of their time treating adults, less than a quarter with mixed client populations, then children and

adolescents (less than a fifth of their time), and finally families, older adults, or groups (less than 2%) (Petrovic-Poljak et al., 2010).

PAA member psychologists spent 41% of their time in Calgary, 38% in Edmonton, 4% in northwest Alberta, 3% in other central Alberta, 3% in greater Red Deer, 3% in northeast Alberta, 2% in Medicine Hat, and less than 1% in Lethbridge and other parts of southern Alberta (Petrovic-Poljak et al., 2010). Three percent of PAA member psychologists practiced elsewhere in Canada (outside of Alberta) and another 2% practiced internationally (Petrovic-Poljak et al., 2010).

The number of PAA member psychologists with doctoral degrees increased with age (50% of psychologists aged 55 or above vs. 10% of psychologists aged 30 or less), however, there were more PAA member psychologists who held master's degrees in the younger age groups (90% of those aged 30 years or less vs. 50% of those aged 55 years or above; Petrovic-Poljak et al., 2010). Tieu, Dobson and Berube (2008) and Petrovic-Poljak et al. (2010) state that Alberta is fast becoming a province in which most registered psychologists practice with a master's-level degree only. Of those PAA member psychologists aged 29 or lower, only approximately 5% held doctoral degrees; however; of those PAA member psychologists aged 65-plus closer to 50% held doctoral degrees (Petrovic-Poljak et al., 2010). There appear to be more PAA member psychologists at a master’s level in the areas of clinical and counselling psychology than those at a doctoral level (Petrovic-Poljak et al., 2010). Female psychologists consistently and significantly outnumber male across all age

groups, indicating that psychology in Alberta is skewed heavily female (Petrovic-Poljak et al., 2010).

Procedure

Potential participants were recruited via both the Canadian Psychological Association (CPA) and the Psychologists' Association of Alberta (PAA), both of which are voluntary membership professional associations, with the former being a national association and the latter being a provincial one.

CPA members were recruited via the email listserv of selected sections which indicated a willingness to allow participant recruitment (see Appendix Y for recruitment email used), as well as via the online CPA Recruit Research Participants Portal (see Appendix Z for portal recruitment poster). Those CPA sections which agreed to allow participant recruitment included the following:

1. CPA Women and Psychology Section listserv.
2. CPA Traumatic Stress Section listserv.
3. CPA Substance Abuse/Dependence Section listserv.
4. CPA Sport & Exercise Psychology Section listserv.
5. CPA Social and Personality Section listserv.
6. CPA Sexual Orientation and Gender Identity Section listserv.
7. CPA Extremism and Terrorism Section listserv.
8. CPA Developmental Section listserv.
9. CPA Criminal Justice Psychology Section listserv.
10. CPA Clinical Neuropsychology Section listserv.
11. CPA Clinical Section listserv.

12. CPA Counselling Section listserv.

The only method of survey completion available to those participants recruited via the CPA was online. It is not possible to know how many CPA members were exposed to the email recruitment digital letter and, as a result, how many followed up by visiting the online survey site.

PAA members were recruited via mail (see Appendix AA for letter used in mail recruitment) and online research flyer (see Appendix BB for online flyer used). The online research flyer was placed on the PAA website and interested viewers were directed to the online version of the surveys. A membership mailing list was purchased from the PAA that included members that were Fully Registered Psychologists, Out of Province members, and Life members, all of whom had voluntarily indicated a willingness to be contacted about non-PAA specific matters. A total of 802 survey packages were mailed out to PAA members. PAA members who received the mailed survey package were given the option of completing the surveys online or returning the completed paper surveys by mail.

The three surveys participants were asked to complete are as follows, in chronological order:

1. The Client Vignette Scoring Instrument, Version 3 (see Appendix CC for the online version and Appendix DD for the mail version).
2. A Modified version of the Sexual Opinion Survey-Revised (see Appendix EE for the online version and Appendix FF for the mail version).

3. A demographic survey (see Appendix GG for the online version and Appendix HH for the mail version).

Participants were recruited who confirmed being ***both*** currently practicing Psychologists or Psychological Associates ***and*** who confirmed registration with their respective provincial regulatory body.

Instruments

Client Vignette Scoring Instrument - Version 3 (CVSI-V3). The Client Vignette Scoring Instrument Version 3 (CVSI-V3) is composed of three fictional client case vignettes (Jeff, Sophie, and Bill). Each case has been designed to contain within it a specific and different number of criteria for Cybersex Addiction (CSA) as well as a fixed number of criteria for Major Depressive Disorder (MDD) and Obsessive Compulsive Disorder (OCD). The latter two diagnoses (MDD and OCD) are included as they represent the diagnoses often chosen instead of CSA by clinicians when encountering clients with CSA or Sex Addiction (SA), but often exist secondary to the addictive process and not as the primary presenting problem in need of treatment. The maximum number of MDD and OCD diagnostic criteria have been built into the design of each case. The client case vignette of Jeff holds the least number of CSA diagnostic criteria with only one CSA diagnostic criteria built into the design of the case. The client case vignette of Sophie has three CSA diagnostic criteria built into the design of the case. The client case vignette of Bill holds the most number of CSA diagnostic criteria with the maximum number of CSA diagnostic criteria – nine – built into the design of the case.

There are two questions following each client case vignette in the CVSI-V3. Question 1 focused on asking participants to identify and select the top five presenting problems that they identified were illustrated in the preceding case (Jeff, Sophie, or Bill) from a provided list and rank them from 1 (*primary presenting problem in need of therapeutic attention*) to 5 (*most peripheral therapeutic problem in need of therapeutic attention*). Included in the list was the category of Cybersex Addiction as well as that of Sex Addiction.

Question 2 invited participants to respond to a series of symptoms using a 5-point Likert rating ranging from 0 (*not at all contributing*) to 4 (*a key contributor*) to indicate the degree to which they perceived the symptom to be contributing to the overall presenting problem of the client in the preceding case (Jeff, Sophie, or Bill). There were 18 symptoms listed under Question 2, of which nine represented CSA with the remainder representing selective (but not exhaustive) MDD and OCD diagnostic criteria.

The responses to each of the client case vignettes were scored separately yielding an individual CSA Subscale Score for each of the three cases (Jeff, Sophie and Bill). The CSA Subscale Scores for each case exist within the range of 0 (min) to 28 (max). The minimum number of diagnostic criteria required to meet the diagnosis of CSA was three, which meant that in each of the three client vignette cases (Jeff, Sophie, and Bill) the minimum cut-off CSA Subscale Score indicating perception by the respondent of CSA is a 9.

As indicated above, the client case vignette of Jeff had only one CSA diagnostic criteria built into the design of the case, and therefore an individual

who accurately perceived the presence of the one CSA diagnostic criteria built into the design of the case of Jeff would score a minimum CSA Subscale Score of 3. As the client case vignette of Sophie had three CSA diagnostic criteria built into the design of the case, an individual who accurately perceived the presence of the three CSA diagnostic criteria built into the design of the case of Sophie would score a minimum CSA Subscale Score of 9. Finally, as the client case vignette of Bill had nine CSA diagnostic criteria built into the design of the case, an individual who accurately perceived the presence of the nine CSA diagnostic criteria built into the design of the case of Bill would score a minimum CSA Subscale Score of 21.

Modified Sexual Opinion Survey-Revised (SOS-R-M). It has been proposed that an individual's sexual attitude may influence their acceptance of and comfort with sexual content, behaviour and issues (Fisher, White, et al., 1988; Kelley, 1985; Byrne, 1982 as cited in Kelley, 1985; Murray et al., 2007; Schnarch, 1992; Swisher, 1995). This is particularly important among psychologists given that discomfort with sexual matters reduces the chances that a sexual history will be gathered and that sexual issues/concerns will be asked about. The Sexual Opinion Survey – Revised (SOS-R; Appendix R) was selected and adapted into the Modified Sexual Opinion Survey (SOS-R-M; Appendices EE and FF) for use in this study as a measure of psychologists' erotophobic-erotophilic tendencies due to its strong validity and reliability.

The Sexual Opinion Survey – Revised (SOS-R; Appendix R) is a 21-item measure of erotophobic-erotophilic tendencies in response to sexual cues along a

7-point Likert scale dimension of evaluation and emotion (Fisher, White, et al., 1988). This measure scores in a range from 0 to 126, with scores towards 0 indicating a negative response to erotic cues (erotophobia) and towards 126 indicating a positive response to erotic cues (erotophilia). The SOS-R is composed of three main factor clusters: open sexual display, sexual variety, and homoeroticism, and they account for 34%, 11% and 7% of the overall variance in SOS-R scores respectively (Fisher, White, et al., 1988; Gilbert & Gamache, 1984).

The SOS-R is based on the original Sexual Opinion Survey (SOS) and is the result of minor changes in wording to the SOS that were intended to bring the scale up to date, such as the replacement of “pornography” and “go-go dancer” with “erotica” and “stripper,” respectively, where appropriate (Fisher, White, et al., 1988). The correlation between the SOS and the SOS-R is very high (r[321] = 0.92, $p < .001$) and mean scores on the two versions did not differ significantly among males (t[105] = 1.27, n.s.) or females (t[214] = 0.55, n.s.) leading the SOS-R to be recommended for future research over the SOS (Fisher, White, et al., 1988).

Convergent validity of the SOS has been suggested through the significant relationship between the SOS and emotional reactions to erotica among males (r = 0.61, $p < .001$) and females (r = 0.72, $p < .001$) (Campbell & Fiske, 1959; Fisher, White, et al., 1988). Discriminant validity was also demonstrated through the non-significant relationship between SOS scores and scores of social desirability among males (r = 0.05) and females (r = -0.05) (Campbell & Fiske, 1959; Fisher,

White, et al., 1988). Internal reliability for the SOS is high (0.88; Campbell & Fiske, 1959; Fisher, White, et al., 1988), as is split-half reliability (0.77; Gilbert & Gamache, 1984) and test-retest reliability (0.84; Tanner & Pollack, 1988).

As there is no mention of sexual content accessed through the Internet in the SOS-R, one of the changes made in the Modified Sexual Opinion Survey – Revised (SOS-R-M; Appendices EE and FF) is in the explanation of the term erotica in Questions 1, 2, 15, and 20 (Yassa, 2005). The delimiter in those questions of "sexually explicit books, movies, etc." was replaced with "sexually explicit Internet sites, chat rooms, books, magazines, movies, etc." For similar reasons, in Question 9 the delimiter of "movie" was replaced with "movie/on-line video/Internet site/on-line Chat/magazine/book."

Demographic survey. The demographic survey was composed of 19 question items, some with sub-questions, and was administered as the last of the three surveys to Phase II participants (see Phase II demographic survey in Appendix GG for the online version, and Appendix HH for the mail version). The first two question items of the demographic survey were selection/filter questions used to identify whether those individuals who consented to be a part of Phase II of the study actually met the selection criteria to do so. These filter items included questions about whether the participant was (a) registered in the College of Psychologists of their respective province (including which province and what associations they were a member of), and (b) currently practicing as a psychologist. Items 3 through 19 were used to describe the Phase II participants and were composed of questions about education, number of years practicing,

specialization, workplace, age, gender, ethnicity, relationship status, sexual orientation, computer and Internet familiarity and usage, and amount of training received in sex/cybersex addiction.

As in Phase I, the Pilot, constructs, like ethnicity and computer and Internet comfort and familiarity were measured through the use of more than one question due to the complex nature of the construct. The question of ethnicity was, as in the pilot, addressed in two parts composed of what participants' self-reported ethnicity and how long they had lived in Canada.

Also, as in the pilot, six questions were designed to measure participant familiarity and comfort with using the computer and the Internet. It was anticipated that the number of hours of use and number of purposes selected would serve as an alternative descriptive indication and confirmation of participants' comfort and expertise of use of the computer (Potosky & Bobko, 1998; Smith et al., 1999) and Internet, as well as augment the self-report questions regarding participants' rated level of comfort with their use.

Ethical Considerations

As in Phase I: Pilot, the ethical procedures outlined here are a reflection of the values, principles and standards derived from the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research *et al.*, 1998, with 2000, 2002, & 2005 amendments), the Canadian Psychological Association (CPA) Canadian Code of Ethics for psychologists (Canadian Psychological Association, 2000), and the University of Alberta Standards for the Protection of Human Research Participants (University

of Alberta, n.d.). This phase of the research project, as with the previous phase, was designed in agreement with the guidelines and requirements therein.

Free and informed consent. Phase II participants were provided a consent form (Appendix II for the online version, Appendix JJ for the mailed version) indicating that the purpose of the research was to examine therapists' identification of the presenting problems of clients using fictional vignettes and the relationship that therapists personal and professional characteristics may play in those identifications. Phase II participants were advised that their participation would involve the completion of three questionnaires which would include three written client vignettes and subsequent questions about participants' thoughts on the issue for the client represented in the vignette, questions about their sexual attitudes, and personal and professional demographic questions. They were also informed in the consent form of the potential risks (low to nil) of participating, how their confidentiality would be protected, the investment of time (30 – 35 minutes), the benefits of participation, their rights as participants, information about withdrawal (e.g., they would be unable to due to anonymity), the researchers plans for the data, and who to contact should they have further questions. Participants were provided the opportunity to freely accept or decline participation with no negative consequences.

Partial disclosure. Partial disclosure was considered a necessity in this phase of this study, as it had been with the pilot phase, as full disclosure of the research goal would bias participants towards perceiving the presence of cybersex addiction in the vignettes, thereby defeating the purpose of the research.

However, it was deemed that the risks to the pilot participants of such partial disclosure would be minimal to nil due to their training as psychologists, which rendered them a non-vulnerable population. The risks of partial disclosure therefore were assessed to not outweigh the benefits to the research.

Phase II participants were advised in the consent form that they could go to an indicated web address as of July 1, 2010 to read a full explanation of the study, and that this web address and the explanation therein would be available to access for a period of one month. The date chosen to make the debrief website available (July 1, 2010) was based on a cut-off date after which no more data would be collected by the researcher. This ensured that all participants (pilot and otherwise) would have had access at the same time to the debriefing, reducing the chances that the real purpose of the study might have been leaked to potential future participants who had yet to completed the surveys. The debrief website was left up for one month which, it was determined, would allow interested participants adequate time to access it.

Phase II participants were advised in the consent form and again at the end of the surveys that once they clicked “Done” and submitted their completed surveys to the researcher that withdrawal would not be an option. Phase II participants were advised that this inability to withdraw their data after submission was due to the anonymity of the surveys and the fact that the researcher had not collected any information linking the surveys to the individual participant.

Right to withdraw. All efforts were made to minimize any potential

harm or risk to the research participants, although it was acknowledged in the online consent form that some (albeit, it was anticipated, few) participants might possibly experience mild discomfort with the sexual content of some of the survey questions (i.e., those of the SOS-R-M). Phase II participants were advised in the online consent form that if, at any time, they decided they did not wish to continue with the surveys they were free to exercise their right to withdraw by simply discontinuing their online surveys session at no consequence to themselves.

Anonymity. Individuals recruited to respond to self-report surveys containing sensitive (e.g., sexual) material are more likely to participate when anonymity, rather than merely confidentiality, is provided by researchers (Durant et al., 2002). Steps were taken to ensure the anonymity of Phase II participants by even removing the function in the online surveys that drops a cookie into the participants' computer cache as was done in Phase I.

Additionally, Phase II participants were assured of their anonymity throughout this study, both in the recruitment materials as well as in the consent form and at the end of the surveys. At no point were they asked to enter any specifically identifying information during the survey process. The online survey website generated for each Phase II participant a random string of numbers to act as an ID, and participants who received the mailed surveys were asked to create their own anonymous ID of four digits (using a process designed to reduce likelihood of replication; Carifo & Biron, 1978; see Appendix KK).

Privacy and confidentiality. Phase II participants self-selected to

participate by either clicking on the link provided in the email they received or the online poster, or by completing and choosing to return the written surveys in the stamped self-addressed envelopes provided. Despite there being no identifying information collected via any of the measures, all surveys submitted were stored securely in a locked filing cabinet, and participants were assured in the consent form that this would be the case for a period of no less than five years.

Incentive. Phase II participants were advised that the benefit to them of participating included the knowledge that they had contributed something of value to the knowledge base of the profession and assisted indirectly in helping other therapists (including other graduate students and seasoned professionals) learn about their role in the therapeutic assessment process. No other incentive was provided in part due to the fact that this may have required collection or access by the researcher of some identifying information.

Chapter 5 – Results

Argument for Raising Alpha from .05 to .10

Committing a Type I error refers to the act of rejecting the null hypothesis (H_0) when it is true. This is also called an alpha error (α) and the risk of this type of error can be controlled by lowering the alpha (α) level to be more conservative in interpretation of statistics. Decreasing the likelihood of a Type I error by reducing the alpha level, however, increases the likelihood of a Type II error.

Committing a Type II error refers to the act of accepting the null hypothesis (H_0) when it is false. This is also called a beta error (β) and is also problematic. The Type II error is influenced by a number of factors including sample size and effect size. Decreasing the likelihood of a Type II error by raising the alpha level increases the likelihood of a Type I error.

Increasing alpha from the standard .05 to .10 leads to an increased risk of committing a Type I error (or raising a false alarm). However, given that this research is exploratory, keeping alpha at .05 may increase the risk of committing a Type II error (or being under-sensitive in interpreting the data). The degree of risk of incorrectly concluding that the null hypothesis (H_0) is false when it is true (Type I Error) in this research is not considered to be as serious as that of accepting a null hypothesis (H_0) when it is false (Type II Error).

The implications of committing a Type I Error are that, at worst, areas of intervention for further training and research will be incorrectly identified resulting in psychologists who may be unnecessarily further trained. While this may result in the unnecessary expenditure of time and resources, it would simply

yield a further trained group of clinicians, the result of which may benefit the client population served, in particular those with cybersex addiction seeking treatment.

The implications, however, of committing a Type II Error are more serious. Decreasing the alpha level (or maintaining it at the standard .05) may result in important relationships/differences being missed due to under-sensitivity of the data interpretation. In this exploratory type of research missing important relationships/differences that may suggest further areas of necessary training for psychologists may result in clinicians not being identified as in need of further training. The implications of such a misidentification of further training for psychologists (and indeed further follow-up research) poses a greater risk for the client population served, again in particular those with cybersex addiction seeking treatment. So, based on the assessment of these risks, the researcher is prepared to accept the risk of committing a Type I Error and the implications therein by raising alpha, and therefore alpha has been set at .10.

The use of an alpha of .10 is appropriate when studies have an elevated probability of encountering a Type I error[13]. The selection of an alpha of .10 improves the overall power of the test and can be of great benefit to studies with a relatively small sample size (Cohen, 1969; Lipsey, 1990; Stevens, 1986). A number of different studies (Bell & Cooke, 2003; Braithwaite & Fincham, 2011; Collins-McNeil, 2006; Joeng, 2003; Johansson et al., 2010; Johnson, Wardlow, &

[13] See Skipper, Guenther, and Nass (2006) for more about the convention of using an alpha of .05 in social sciences research, its origin, and the contexts in which deviation from this convention is warranted and advisable.

Franklin, 1997; Lang, Bradley, Schneider, Kim, & Mayell, 2012; Lev et al., 2004; Miciano, 2011; Wingenbach, Ladner, Newman, & Raven, 2003) provide examples of investigations that have successfully used an alpha of .10 as part of their investigatory endeavors.

Results

A total of 171 recorded respondents visited the online survey website. The mean length of time it took them to complete the survey online was 27 minutes and 51 seconds. Times ranged from 15 seconds to 22 hours, 47 minutes and 47 seconds. Unfortunately, no data are available regarding the length of time it took respondents to complete the paper surveys. A total of 92 paper surveys were returned by mail, reflecting an 11.47% overall response rate for the mailed surveys. Of the paper surveys received by mail, 39 were not entered because the recipient indicated that they were retired, the survey was marked "return to sender," or the survey was post-marked after the June 30, 2010 cut-off deadline (at which time full disclosure of the true purpose of the study would have been posted online). The remaining 53 paper surveys entered in the data represent a 6.61% response rate of those surveys mailed. As a result of this initial filter, data from a total of 224 psychologists (who completed surveys via online and mail) were entered into the dataset.

Of the total 224 research respondents, 11.6% (n = 26) of respondents indicated they were not registered in the College of Psychologists of their respective province, 78.1% (n = 175) confirmed registration in the College of Psychologists of their respective province, and 10.3% (n = 23) did not answer this

question. Additionally, 4.9% (*n* = 11) of the 224 respondents indicated they were not currently practicing, 84.8% (*n* = 190) endorsed currently practicing, and 10.3% (*n* = 23) did not answer this question. Only data from those individuals who confirmed *both* being currently practicing Psychologists or Psychological Associates *and* who confirmed registration with their respective provincial regulatory body were included in the analysis.

Of the 224 initial respondents, 25% (*n* = 56) identified themselves as being members of the PAA only, 51.8% (*n* = 116) identified as CPA members only, 9.8% (*n* = 22) identified as being members of both the CPA and the PAA, 4% (*n* = 9) identified as being members of neither the CPA nor PAA, and 9.4% (*n* = 21) did not answer this question. Also, of the 224 respondents, 37.1% (*n* = 83) endorsed being registered in Alberta, 22.3% (*n* = 50) in Ontario, 7.1% (*n* = 16) in British Columbia, 3.6% (*n* = 8) in Manitoba, 2.2% (*n* = 5) in New Brunswick, 2.2% (*n* = 5) in Nova Scotia, 1.8% (*n* = 4) in Saskatchewan, 1.3% (*n* = 3) in Newfoundland and Labrador, 0.9% (*n* = 2) in Quebec, 0.4% (*n* = 1) in Northwest Territories, and 21% (*n* = 47) did not answer this question.

Data cleaning. The data were cleaned to distill them to a data set of research participants that could be used consistently in all analyses, thereby increasing generalizability of findings. Also, given the exploratory nature of the research study and the resulting increase in alpha to .10, the use of a more stringent and conservative data cleaning approach acted similarly in function to Bonferroni's correction in that it compensated for the increased alpha.

In the first step of data cleaning, of the initial 224 study respondents, those who did not meet the screening criteria (i.e., fully registered and currently practicing) were filtered out, resulting in 172 research respondents remaining. Since completion of the SOS-R-M was mandatory for online respondents to move on to the demographic survey it stood to reason that those who had not completed the SOS-R-M online would also not have completed the demographic survey. This meant that no independent variables would have been collected for those online respondents. Therefore, for both online and mail respondents, the second step of data cleaning involved filtering out those respondents who had not completed the SOS-R-M. This second step resulted in only 97 study respondents remaining within the dataset.

Participants were recruited using two different case orders of the CVSI-V3, one of which had the case of Jeff preceding that of Sophie and Bill, respectively, and the other had the case of Jeff following Bill and Sophie, respectively. In the third data cleaning step, respondents who had not completed all the question items for the case of Jeff were filtered out, resulting in 95 research respondents remaining. In the fourth and final step, those respondents who had not completed all the question items for the case of Bill were filtered out, resulting in a final total sample size of 93 research participants. This sample size of 93 reflects 54.07% that completed all three surveys out of the 172 respondents who fit selection criteria (as compared to 44.44% in Phase I). All further statistical analysis reported is based on this remaining cleaned sample of 93 viable respondents.

Demographics. All 93 research participants (100%) confirmed *both* registration in the College of Psychologists of their respective province *and* currently practicing. Of those 93 participants, 50.5% (*n* = 47) completed the surveys online, while the remaining 49.5% (*n* = 46) completed it via mail. Of the 47 respondents who completed the survey online and the mean length of time it took them to complete the survey online was 50 minutes, 52 seconds (*SD* = 49 minutes, 55.4 seconds), the median completion time was 39 minutes, 24 seconds, and the (smallest) mode was 18 minutes, 54 seconds. Length of completion time for online participants ranged from 18 minutes, 54 seconds to 5 hours, 51 minutes, 28 seconds; however, no completion time information was available for those 46 participants who completed paper surveys via mail.

Professional. Of the 93 participants, 49.5% (*n* = 46) identified themselves as being members of the PAA only, 44.1% (*n* = 41) identified as CPA members only, and 6.5% (*n* = 6) identified as being members of both the CPA and the PAA. Also, 59.1% (*n* = 55) of the 93 participants endorsed being registered in Alberta, 20.4% (*n* = 19) in Ontario, 7.5% (*n* = 7) in British Columbia, 3.2% (*n* = 3) in Nova Scotia, 3.2% (*n* = 3) in Saskatchewan, 3.2% (*n* = 3) in Manitoba, 1.1% (*n* = 1) in New Brunswick, 1.1% (*n* = 1) in Newfoundland and Labrador, and 1.1% (*n* = 1) in Northwest Territories.

Just under 41% (*n* = 38) of the 93 participants endorsed holding a Master's degree as the highest level of education they had completed, 58.1% (*n* = 54) endorsed holding a Ph.D., and 1.1% (*n* = 1) endorsed holding a Psy.D. When the categories were collapsed into Master's and Doctoral, data showed that 40.9% (*n*

= 38) participants held a Master's degree and 59.1% (*n* = 55) held a Doctoral degree as the highest level of education completed. The mean number of years in practice endorsed by this group was 14.99 years (*N* = 93, *SD* = 10.37), while the median was 12 years, and the mode was 5 years. Participants' number of years in practice ranged from 1 year to 45 years.

The population of specialization among the 93 participants was identified as being "Adults" among 87.1% (*n* = 81), followed by "Couples" among 43% (*n* = 40), "Families" among 34.4% (*n* = 32), "Children" among 33.3% (*n* = 31), "Adolescents" among 49.5% (*n* = 46), and "Other" among 3.2% (*n* = 3). The category of "Other" consisted of "Disabled," "Seniors," and "Organizations." Participants were instructed to select all that applied. The majority of psychologists by far indicated they were currently working in a "Private Practice" setting (65.6%, *n* = 61). "Inpatient" and "outpatient hospital" wards were identified as a current workplace setting by 7.5% (*n* = 7) and 19.4% (*n* = 18), respectively, of participants. Psychologists who identified themselves as currently working in a "Correctional Facility" amounted to 8.6% (*n* = 8), while 5.4% (*n* = 5) indicated a "Non-profit Agency," 11.8% (*n* = 11) indicated "School" and 10.8% (*n* = 10) indicated "Community Service Centre" as their current workplace settings. A small group of respondents identified that their current workplace setting fell under "Other" (10.8%, *n* = 10), which consisted of "For Profit Agency," "Addictions Agency," "Residential Care," "Mental Health Clinic," "Health Clinic," "University" (*n* = 3), "Organizational," and "Unspecified." Participants were instructed to select all that applied.

Using a 7-point Likert ranging from 0 (*No Training At All*) to 6 (*Extensive Training*), participants rated the mean amount of training they have received in Sex/Cybersex Addiction as 1.48 (N = 91, SD = 1.75) and ratings ranged from 0 to 6. Median amount of training received in Sex/Cybersex Addiction was a rating of 1, and the mode was 0. Of the 91 participants who answered this question, 42.9% (n = 39) indicated they had had "No Training At All" (a rating of "0"), 19.8% (n = 18) rated themselves a "1," 9.9% (n = 9) rated themselves a "2," 13.2% (n = 12) rated themselves a "3," 5.5% (n = 5) rated themselves a "4", 5.5% (n = 5) rated themselves a "5," and 3.3% (n = 3) rated themselves as having received "Extensive Training" (a rating of "6") in Sex/Cybersex Addiction.

Personal. The mean age of the participating psychologists was 47.63 years (N = 92, SD = 11.01). Median age of participants was 47.5 years, the mode was 52 years, and age ranged from 26 to 80 years. Female psychologists represented 72% (n = 67) of the participating sample, while males represented 28% (n = 26).

"Married" psychologists made up 60.2% (n = 56) of the sample, followed by "Common-Law" (10.8%, n = 10), "Single" (10.8%, n = 10), "Divorced" (6.5%, n = 6), "In a Monogamous Relationship" (5.4%, n = 5), "Casually Dating" and "Widowed" (2.2%, n = 2, each respectively), and "Separated" or "Other" (1.1%, n = 1, each respectively). In response to the variable of "Current Relationship Status," the category of "Other" consisted of "Common-Law (with primary partner) in a polyamorous relationship" and participants were instructed to select only one. Re-grouping of the data for relationship status resulted in 78.5% (n =

73) of the 93 participants apparently indicating they were in some sort of relationship with a partner, 20.4% (*n* = 19) indicating they were not currently in a relationship, and 1.1% (*n* = 1) indicating the category of "Other." The majority of participant psychologists identified themselves as completely Heterosexual (69.9%, *n* = 65) on Kinsey's (Kinsey, Pomeroy, & Martin, 1948; The Kinsey Institute for Research in Sex, Gender, and Reproduction, 2013) 7-point sexual orientation scale (in which 1 = *Heterosexual* and 7 = *Homosexual*), while only 2.2% (*n* = 2) identified themselves as completely Homosexual, and the remainder gave themselves a rating of "2" ("mostly heterosexual"; 17.2%, *n* = 16), "3" ("more heterosexual than homosexual"; 3.2%, *n* = 3), "4" ("bisexual"; 2.2%, *n* = 2), "5" ("more homosexual than heterosexual"; 3.2%, *n* = 3), and "6" ("mostly homosexual"; 2.2%, *n* = 2). Participants' mean sexual orientation was 1.67 (*N* = 93, *SD* = 1.38), while the median and mode were both 1.00.

Ethnicity is a complex construct and for the purposes of this research was derived from individuals' responses to two questions; self-identified ethnicity and number of years lived in Canada. Most psychologists identified themselves as being of Canadian ethnicity (80.6%, *n* = 75), followed by British Isles (3.2%, *n* = 3), Scandinavian (2.2%, *n* = 2), Eastern European (2.2%, *n* = 2), Latin, Central & South American (2.2%, *n* = 2), Other (2.2%, *n* = 2; including "WASP" and "Canadian with strong Ukrainian values"), Northern European (1.1%, *n* = 1), Western European (1.1%, *n* = 1), Other European (1.1%, *n* = 1), Middle-Eastern/Arab (1.1%, *n* = 1), and East & Southeast Asian (1.1%, *n* = 1). Participants were instructed to select only one category from the above. The

mean number of years psychologists in this sample indicated they had lived in Canada is 43.87 (*N* = 92, *SD* = 13.98), with the range spanning 2 to 80 years. Both the median and (smallest) mode number of years lived in Canada was 43 years.

Computer/Internet familiarity. Four approaches to identifying participants' familiarity with computers and the Internet were utilized, including their self-rated comfort with using each, their personal and professional time usage of each, and the number of purposes for which they use each. For the purposes of answering specific research questions participants' self-rated comfort was used.

Of the 93 psychologists, 7.5% (*n* = 7) identified themselves as being "Extremely Uncomfortable Using a Computer" using a 5-point Likert (ranging from 1 = *Extremely Uncomfortable* to 5 = *Extremely Comfortable*), while 49.5% (*n* = 46) identified themselves as being "Extremely Comfortable Using a Computer," and the remainder gave themselves a rating of "2" (2.2%, *n* = 2), "3" (14%, *n* = 13), and "4" (26.9%, *n* =25). The mean rating for comfort with using a computer was 4.09 (*SD* = 1.19), the median was 4 and the mode was 5. Regarding their comfort with using the Internet on the same 5-point Likert scale as above, 47.3% (*n* = 44) rated themselves as "Extremely Comfortable Using the Internet," while 6.5% (*n* = 6) rated themselves as "Extremely Uncomfortable," 3.2% (*n* = 3) rated themselves as a "2," 14% (*n* = 13) rated themselves a "3," and 29% (*n* = 27) rated themselves a "4." The mean rating for comfort with using the Internet was 4.08 (*SD* = 1.15), the median was 4 and the mode was 5.

The number of hours per week that psychologists used both the computer and the Internet was divided into personal and professional use. One participant (1.1%) out of the 92 participants who responded to this question item indicated that they spent "0 hours" per week using the computer for personal purposes, while 41.3% (*n* = 38) endorsed using it for "1 - 5 hours" per week, 23.9% (*n* = 22) endorsed using it for "6 - 10 hours" per week, 27.2% (*n* = 25) indicated they used it for "11 - 20 hours" per week, 4.3% (*n* = 4) indicated they used it for "21 - 30 hours" per week, and 2.2% (*n* = 2) endorsed using it for "31 - 40 hours" per week. Regarding the number of hours per week participants used the Internet for personal purposes, 1.1% (*n* = 1) indicated they spent "0 hours," 57.6% (*n* = 53) reported they spent "1 - 5 hours" per week, 25% (*n* = 23) spent "6 - 10 hours," 13% (*n* = 12) spent "11 - 20 hours," 1.1% (*n* = 1) said they spent "21 - 30 hours," and 2.2% (*n* = 2) reported spending "31 - 40 hours" per week using the Internet for personal purposes.

Of the 91 participants who provided information about their usage of the computer for professional purposes, 15.4% (*n* = 14) endorsed using it for "1 - 5 hours" and "6 - 10 hours" each per week, 34.1% (*n* = 31) said they spent "11 - 20 hours" per week doing so, 20.9% (*n* = 19) indicated professional computer use of "21 - 30 hours" per week, 8.8% (*n* = 8) reported "31 - 40 hours" per week usage, 3.3% (*n* = 3) spent "41 - 50 hours" per week, and 2.2% (*n* = 2) endorsed using the computer for professional purposes for "50+ hours" per week. One participant (1.1%) out of 91 indicated that they used the Internet for professional purposes for a total of "0 hours" per week, while 50.5% (*n* = 46) reported they spent "1 - 5

hours" per week, 24.2% (*n* = 22) spent "6 - 10 hours" per week, 13.2% (*n* = 12) spent "11 - 20 hours" per week, 7.7% (*n* = 7) spent "21 - 30 hours" per week, 2.2% (*n* = 2) spent "31 - 40 hours" per week, and 1.1% (*n* = 1) endorsed spending "50+ hours" per week.

The number of purposes for which psychologists in this group identified generally using the computer ranged from 1 to 21 (*N* = 92, *M* = 8.21, *SD* = 3.98), and ranged from 1 to 19 (*N* = 93, *M* = 8.31, *SD* = 3.90) when using the Internet.

Modified Sexual Opinion Survey - Revised (SOS-R-M). The mean total score on the Modified version of the Sexual Opinion Survey-Revised (SOS-R-M) for the 93 psychologists is 79.72 (*SD* = 18.73), while the median and mode are both 83. Total scores on the SOS-R-M exist on a continuum ranging from 0 (*most erotophobic*) to 126 (*most erotophilic*) and respondents total scores specifically ranged from 28 to 117. When the median is used as the cut point for the SOS-R-M, 49.5% (n = 46) then fall below the cut point and can be categorized as (relatively) erotophobic, and 50.5% (*n* = 47) fall above the cut point and can be categorized as (relatively) erotophilic. Fisher's measure of skewness and kurtosis for the SOS-R-M yielded -1.86 and -0.05, respectively, thereby suggesting a relatively normal distribution. However, results of the Shapiro-Wilk test for normality equaled 0.934 (*df*, 42), *p* = 0.02 suggesting a moderately non-normal distribution.

Client Vignette Scoring Instrument - Version 3 (CVSI-V3). The Client Vignette Scoring Instrument (CVSI) is composed of three fictional client case vignettes (Jeff, Sophie, and Bill). Each case has been designed to contain within

it a specific and different number of criteria for Cybersex Addiction (CSA), as well as a fixed number of criteria for Major Depressive Disorder (MDD) and Obsessive Compulsive Disorder (OCD). The latter two diagnoses (MDD and OCD) are included as they represent the diagnoses often chosen instead of CSA by clinicians when encountering clients with CSA or Sex Addiction (SA), but often exist secondary to the addictive process and not as the primary presenting problem in need of treatment. The maximum number of MDD and OCD diagnostic criteria have been built into the design of each case. The client case vignette of Jeff holds the least number of CSA diagnostic criteria with only one CSA diagnostic criteria built into the design of the case. The client case vignette of Sophie has three CSA diagnostic criteria built into the design of the case. The client case vignette of Bill holds the most number of CSA diagnostic criteria with the maximum number of CSA diagnostic criteria – nine– built into the design of the case.

There are two questions following each client case vignette in the CVSI-V3. Question 1 focuses on asking participants to select and rank the top five presenting problems that they believe are illustrated in the preceding case (Jeff, Sophie, or Bill) from a provided list. Included in the list is Cybersex Addiction, and also included is the broader category of Sex Addiction. In response to the case of Jeff, 0% of 92 participants identified the primary presenting problem as being CSA. When the category of Sex Addiction (SA) was combined with that of CSA, 6.5% (n = 6) of 92 participants selected this category as indicative of the primary presenting problem in need of therapeutic attention, while 93.5% (n = 86)

selected something else. In response to the case of Sophie, only 11.8% (*n* = 11) of 93 participants identified CSA as the primary presenting problem in need of therapeutic attention, while 88.2% (*n* = 82) selected something else. Again, however, when the categories of CSA and SA were combined together, 63.4% (*n* = 59) selected it as indicative of the primary presenting problem in need of therapeutic attention in the case of Sophie, while 36.6% (*n* = 34) selected something else. Finally, in response to the case of Bill, only 35.5% (*n* = 33) of the 93 participants identified CSA as the primary presenting problem in need of therapeutic attention, leaving 64.5% (*n* = 60) who selected something else. When the categories of CSA and SA were combined, 57% (*n* = 53) selected it as indicative of the primary presenting problem in need of therapeutic attention in the case of Bill, while 43% (*n* = 40) selected something else.

Question 2 invites participants to respond to a series of symptoms using a 5-point Likert rating ranging from 0 (*not at all contributing*) to 4 (*a key contributor*) to indicate the degree to which they believe the symptom to be contributing to the overall presenting problem of the client in the preceding case (Jeff, Sophie, or Bill). There are 18 symptoms listed under Question 2, of which nine represent CSA, whereas the remainder represent selective (but not exhaustive) and interspersed MDD and OCD diagnostic criteria.

The responses to each of the client case vignettes were scored separately, yielding an individual CSA Subscale Score for each of the three cases (Jeff, Sophie and Bill). The CSA Subscale Scores for each case exist within the range of 0 (min) to 28 (max). The minimum number of diagnostic criteria required to

meet the diagnosis of CSA is three, which means that in each of the three client vignette cases (Jeff, Sophie, and Bill) the minimum cut-off CSA Subscale Score indicating perception by the respondent of CSA is a 9. This is based on a minimum Likert rating of "3," which meant the participant saw the symptom as at least "Somewhat Contributing" to the overall presenting problem of the client indicated in the case.

As indicated above, the client case vignette of Jeff has only one CSA diagnostic criteria built into the design of the case, and therefore an individual who accurately perceives the presence of the one CSA diagnostic criteria built into the design of the case of Jeff would score a minimum CSA Subscale Score of 3. Among the 93 respondents, the mean CSA Subscale Score for the case of Jeff is 13.91 (SD = 6.67), the median is 15 and the mode is 21. Respondents CSA Subscale Scores in response to the case of Jeff range from 1 to 27. Fisher's measure of skewness and kurtosis yielded -0.36 and -1.94, respectively, thereby suggesting a relatively normal distribution. However, results of the Shipiro-Wilk test for normality equaled 0.945 (df, 42), p = 0.04 suggesting a mildly non-normal distribution.

As the client case vignette of Sophie has three CSA diagnostic criteria built into the design of the case, an individual who accurately perceives the presence of the three CSA diagnostic criteria built into the design of the case of Sophie would score a minimum CSA Subscale Score of 9. Among the 93 respondents, the mean CSA Subscale Score for the case of Sophie is 23.28 (SD = 4.29), the median is 24 and the mode is 28. Respondents CSA Subscale Scores in

response to the case of Sophie range from 7 to 28. Fisher's measure of skewness and kurtosis yielded 5.23 and 4.28, respectively, thereby suggesting an extremely non-normal distribution. Results of the Shipiro-Wilk test for normality supported this and equaled 0.878 (*df*, 42), $p < .001$, suggesting an extremely non-normal distribution.

Finally, as the client case vignette of Bill has nine CSA diagnostic criteria built into the design of the case, an individual who accurately perceives the presence of the nine CSA diagnostic criteria built into the design of the case of Bill would score a minimum CSA Subscale Score of 21. The reason for this is that, as per the scoring protocol, only the highest score was selected between Items 1 and 3, and between Items 5 and 7, for inclusion in the CSA subscale, resulting in only seven CSA diagnostic criteria actually being included in the scoring. Among the 93 respondents, the mean CSA Subscale Score for the case of Bill is 24.32 (SD = 4.04), the median is 26 and the mode is 28. Respondents CSA Subscale Scores in response to the case of Bill range from 11 to 28. Fisher's measure of skewness and kurtosis yielded -6.0 and 4.33, respectively, thereby suggesting an extremely non-normal distribution. Results of the Shipiro-Wilk test for normality supported this and equaled 0.804 (*df*, 42), $p < .001$ suggesting an extremely non-normal distribution.

Dealing with non-normally distributed dependent variable. Data for the CVSI-V3 Question 2 CSA Subscales for each of the cases of Jeff, Sophie and Bill suggested mild to severe non-normality. Since the CSA Subscale for each of the three cases is a dependent variable this posed some concerns regarding the

usability of the data in subsequent analysis, given the inherent assumption of normality. As per Field's (2009) and Tabachnick's and Fidell's (2007) caution to only remove outliers if there was good reason to believe that the extreme values were not representative of the population one intended to sample, it was determined by this author that removal of outlier cases was not an option as there was no good reason to assume such. Transforming the data for the CSA Subscales in the case of Jeff, Sophie and Bill was attempted. Square root transformation did reduce the skew and kurtosis in the variables; however, the distribution was still not normal in any of the cases (Shapiro-Wilk, $p < .05$). Natural log transformation resulted in reduced skew and kurtosis in the cases of Sophie and Bill; however, it severely increased the skew and kurtosis in the case of Jeff, in which the skew and kurtosis has been previously mild, and the distribution was again still not normal for any of the cases (Shapiro-Wilk, $p < .05$). A Base-10 log transformation also resulted in reduced skew and kurtosis in the cases of Sophie and Bill, but a severely increased skew and kurtosis in the case of Jeff, and the distribution was still not normal for any of the cases (Shapiro-Wilk, $p < .05$). As a result of this it was determined that attempting to transform the data did not effectively address the issue of non-normality in the dependent variables indicated, and furthermore resulted in the meaningfulness of the results of the CSA Subscale derived from Question 2 of the CVSI-V3 becoming significantly compromised.

The next option examined for dealing with the non-normality of these dependent variables was that of changing or replacing the CSA Subscale outlier

scores either with the next highest or next lowest score, with a score that represented three standard deviations from the mean, or with a score that represented two standard deviations from the mean. Results from all three of these approaches did not change the non-normality of the distributions for the dependent variable in any of the three cases (Shapiro-Wilk, $p < .05$).

When data involving the CVSI-V3 CSA Subscale was re-analyzed using both non-parametric analyses and bootstrapping as alternatives to the initial parametric analyses, results were found to be the same as those found in parametric analysis. Based on this the original parametric analyses were determined to be robust enough to allow for the use of the non-normally distributed dependent variable and therefore results of the parametric analysis were retained.

Research questions. The main question being asked in this study is "can psychologists accurately identify cybersex addiction among clients?" In order to answer this question, the following research questions were explored using the statistical analyses indicated. Tables are presented for each research question to make it easier for the reader to visually follow and compare data from the three vignettes.

Research Question 1. The first research question asks whether cybersex addiction is selected more often than other categories by psychologists in their identification of the presenting problem in the client vignettes of the CVSI. A chi-square test for goodness of fit could not be performed for the case of Jeff, but was performed for each of the cases of Sophie and Bill, when the two groups were

limited to (1) "CSA selected as the primary diagnosis" and (2) "Other Problem diagnosed as primary (not CSA)". A Binomial Test at 50% probability was conducted for the case of Jeff as there were 0 frequencies identified for group 1, resulting in only one group for the statistical analysis. Grouping the categories in this way represented the more technically accurate approach to answering the research question posed. Since CSA can be conceptualized as a form of SA, it was also conceived that a more clinically accurate approach to analyzing the data would be to subsequently group the categories of CSA and SA together and analyses were again conducted using a chi-square test for goodness of fit. Table 1 outlines the findings for Research Question 1.

Table 1

Research Question 1: Summary of Differences in Proportion for All Three Cases of the CVSI-V3

	CSA vs. Other			Either CSA or SA vs. Neither CSA nor SA		
Case	CSA	Other (Not CSA)	χ^2	Either CSA or SA	Other (Neither CSA nor SA)	χ^2
Jeff	0% (*n* = 0)	100% (*n* = 92)	n/a ****±	6.52% (*n* = 6)	93.48% (*n* = 86)	69.57****
Sophie	11.83% (*n* = 11)	88.17% (*n* = 82)	54.20****	63.44% (*n* = 59)	36.6% (*n* = 34)	6.72**
Bill	35.48% (*n* = 33)	64.52% (*n* = 60)	7.84***	57% (*n* = 53)	43% (*n* = 40)	1.82*

Note. ± A Binomial Test at 50% probability was conducted instead of a chi-square test for goodness of fit due to one group with a 0 frequencies; n/a = not applicable.
*p < .10. **p < .05. ***p < .01. ****p < .001.

Jeff. Results of a Binomial Test performed at 50% probability yielded a significant finding at $p < .001$. Range for the calculated[14] 95% Confidence Interval (C.I.) did not span "0" (range +0.40, +0.60) thus supporting this significant Binomial Test finding for the case of Jeff. Results showed there are significantly more participants who thought Jeff's primary presenting problem was something other than CSA (100%, $n = 92$), as compared to those who thought it was CSA (0%, $n = 0$), $p < .001$. It appears that overall the participants were accurately able to discern that CSA was not the primary presenting problem in need of therapeutic attention in the case of Jeff.

Results of a chi-square test for goodness of fit showed there are significantly more participants who thought that Jeff's primary presenting problem was neither CSA nor SA (93.48%, $n = 86$), as compared to those who thought it was either CSA or SA (6.52%, $n = 6$), χ^2 (1, $n = 92$) = 69.57, $p < .001$. Again, even using a more clinically accurate approach to analyzing the data, overall most participants were still able to discern that neither CSA nor SA were the primary presenting problem in need of therapeutic attention in the case of Jeff.

Sophie. Results of a chi-square test for goodness of fit indicated there are significantly more participants who thought Sophie's primary presenting problem was something other than CSA (88.17%, $n = 82$) as compared to those who thought it was CSA (11.83%, $n = 11$), χ^2 (1, $n = 93$) = 54.20, $p < .001$. In the case of Sophie, it appears that overall most participants were not accurately able to

[14] The 95% Confidence Interval for the Binomial Test at 50% probability was calculated using the formula C.I. = $P +/- (z)(Sp)$, where Sp = *the square root of* $[(P)(Q)]/n$, and where $P = 0.5$, $Q = 0.5$, and $z = 1.96$.

discern that CSA was the primary presenting problem in need of therapeutic attention.

Results of a subsequent chi-square test for goodness of fit showed there are significantly more participants who thought that Sophie's primary presenting problem was Either CSA or SA (63.44%, $n = 59$), as compared to those who thought it was Neither CSA nor SA (36.6%, $n = 34$), χ^2 (1, $n = 93$) = 6.72, $p < .05$. As opposed to the more technically accurate approach to answering this research question, in response to the more clinical approach to the question overall most participants were able to accurately discern that Either CSA or SA were the primary presenting problem in need of therapeutic attention in the case of Sophie.

Bill. Results of a chi-square test for goodness of fit indicate that there are significantly more participants who thought Bill should have a primary diagnosis of something other than CSA (64.52%, $n = 60$), as compared to those who thought he should have a primary diagnosis of CSA (35.48%, $n = 33$), χ^2 (1, $n = 93$) = 7.84, $p < .01$. In the case of Bill, it appears that overall most participants were not accurately able to discern that CSA was the primary presenting problem in need of therapeutic attention.

Results of a subsequent chi-square test for goodness of fit showed there was no significant difference in the proportion of participants who thought that Bill's primary presenting problem was Either CSA or SA (57%, $n = 53$), as compared to those who thought it was Neither CSA nor SA (43%, $n = 40$), χ^2 (1, $n = 93$) = 1.82, $p > .10$. Overall, in the case of Bill, participants' responses to the more clinical approach to the question indicated that those who were able to

accurately discern that Either CSA or SA was the primary presenting problem in need of therapeutic attention were not in a significant majority, as compared to those who weren't able to do so.

Research Question 2a. The first part of the second research question asks if there is a relationship among psychologists between the predictor variables of age, number of years of practice, Internet familiarity, cybersex addiction familiarity, and sexual attitude and the outcome variable of their perception of the presenting problem as cybersex addiction in the client vignettes of the CVSI-V3 as measured by CSA Subscale Scores. A multiple linear regression was conducted on a sample of 91 in each case vignette. Table 2 outlines the findings for Research Question 2a.

Table 2

Research Question 2a: Summary of Multiple Linear Regression Analyses for All Three Cases of the CVSI-V3

	Jeff (n = 91)			Sophie (n = 91)			Bill (n = 91)		
Variable	*B*	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Constant	4.80	5.76		25.72	3.66		23.97	3.55	
Age	0.21	0.12	.34*	0.003	0.07	.01	0.05	0.07	.14
Number of Years in Practice	-0.10	0.12	-.15	-0.08	0.08	-.21	-0.12	0.08	-.30
Internet familiarity±	0.26	0.62	.05	-0.21	0.39	-.06	-0.01	0.38	-.002
CSA familiarity$	0.15	0.43	.04	0.60	0.27	.25**	0.46	0.27	.20*
Sexual attitude^	-0.01	0.04	-.02	-0.02	0.02	-.075	-0.01	0.02	-.07
R^2		.058			.072			.057	
F		1.05			1.33			1.02	

Note. ± The variable Internet familiarity is based on the demographic survey question item "comfort with using the Internet"; $ The variable CSA familiarity is based on the demographic survey question item "amount of training received in CSA/SA"; ^ The variable sexual attitude is based on the SOS-R-M Total Score.
*p < .10. **p < .05.

Jeff. Results of a multiple linear regression indicated an R^2 for Model 1 of 0.058, which suggests that only 5.8% of the variance in psychologists perceptions of CSA as the presenting problem in the case of Jeff can be explained by the independent variables in the equation (i.e., age, number of years of practice, Internet familiarity, cybersex addiction familiarity, and sexual attitude). Results of the *F*-test for Model 1 indicated that the percentage of the variance in

psychologists perception of CSA as the presenting problem in the case of Jeff (as measured by CSA Subscale Scores) explained by the IVs (listed above) in Model 1 was not significant, $F(5, 85) = 1.05$, $p > .10$. This means that the regression equation in Model 1 does not explain a significant portion of the variance in psychologists' perceptions of CSA in the case of Jeff, as measured by CSA Subscale Scores.

Sophie. In the case of Sophie, results of a multiple linear regression indicated an R^2 for Model 1 of 0.073, which suggests that only 7.3% of the variance in psychologists perceptions of CSA as the presenting problem can be explained by the predictors in the equation (i.e., age, number of years of practice, Internet familiarity, cybersex addiction familiarity, and sexual attitude). Results of the *F*-test for Model 1 indicated that the percentage of the variance in psychologists perception of CSA as the presenting problem in the case of Sophie (as measured by CSA Subscale Scores) explained by the IVs (listed above) in Model 1 was not significant, $F(5, 85) = 1.33$, $p > .10$. This means that the regression equation in Model 1 does not explain a significant portion of the variance in psychologists' perceptions of CSA in the case of Sophie, as measured by CSA Subscale Scores.

Bill. In the case of Bill, results of a multiple linear regression indicated an R^2 for Model 1 of 0.057, which suggests that only 5.7% of the variance in psychologists perceptions of CSA as the presenting problem in the case of Bill can be explained by the predictors in the equation (i.e., age, number of years of practice, Internet familiarity, cybersex addiction familiarity, and sexual attitude).

Results of the *F*-test for Model 1 indicated that the percentage of the variance in psychologists perception of CSA as the presenting problem in the case of Bill (as measured by CSA Subscale Scores) explained by the IVs (listed above) in Model 1 was not significant, $F(5, 85) = 1.02$, $p > .10$. This means that the regression equation in Model 1 does not explain a significant portion of the variance in psychologists' perceptions of CSA in the case of Bill, as measured by CSA Subscale Scores.

Research Question 2b. The second part of the second research questions asks if there a significant difference between age groups of psychologists on their perception of cybersex addiction as the presenting problem in the client vignettes of the CVSI. Since it was determined there was no theoretical basis for the recoding of the continuous interval data of age that was collected into categorical data, instead the question was revised to ask if there is a significant relationship between psychologists' age and their perception of cybersex addiction as the presenting problems in the case vignettes of the CVSI. A Pearson's product-moment correlation coefficient (*r*) was conducted to determine if measures of age (in years) and psychologists perceptions of cybersex addiction (as measured by CSA Subscale Scores) as the presenting problem were associated among Canadian Registered Psychologists in each of the three cases. Table 3 outlines the findings of Research Question 2b.

Table 3

Research Question 2b: Summary of Correlations Between Psychologists' Age and Perception of CSA as the Presenting Problem for All Three Cases of the CVSI-V3

	Perception of CSA as the Presenting Problem±		
	Jeff	Sophie	Bill
Age (in years)	+0.24*	-0.08	-0.05
n	92	92	92

Note. ±The variable perception of CSA as the presenting problem is measured by the CVSI-V3 CSA Subscale Score.
*p < .05.

Jeff. Results indicated that the relationship between psychologists age and psychologists perceptions of CSA as the presenting problem in the case of Jeff (as measured by CSA Subscale Scores) is a weak positive one, $r(92) = +0.24$, $p < .05$. The relationship between the two variables appears to be significant. When effect size was calculated, however, results showed an R^2(eta) of 0.056, meaning that only 5.6% of the variance in Jeff CSA Subscale Scores can be explained by the Age of the respondents. This leaves over 94% of the variance unexplained.

Sophie. Results indicated that, in the case of Sophie, there was no significant relationship between age and psychologists perceptions of CSA as the presenting problem, $r(92) = -0.08$, $p > .10$.

Bill. Results indicated that there was no significant relationship between age and psychologists perceptions of CSA as the presenting problem in the case of Bill, $r(92) = -0.05$, $p > .10$.

Research Question 3. The third research question asks if there is a

significant difference between erotophilic and erotophobic psychologists on their perception of cybersex addiction as the presenting problem in the client vignettes of the CVSI. A two-tailed independent samples *t*-test was conducted for each of the case vignettes to evaluate if there would be a difference between erotophobic and erotophilic psychologists on their perception of cybersex addiction as the presenting problem (as measured by mean CSA Subscale Scores). The independent variable of sexual attitude was based on the SOS-R-M Total Scores and a cut-point was created, as per previous research (Fisher, 1978, 1980), using the median (83) of the sample. This resulted in those SOS-R-M Total Scores that were less than 83 being categorized as "erotophobic," and those SOS-R-M Total Scores that greater than or equal to 83 being categorized as "erotophilic." Table 4 outlines the findings from the cut-point approach to Research Question 3.

As an alternative to the use of the cut point approach, the question was also asked if there is a significant relationship between sexual attitude and psychologists' perceptions of cybersex addiction (CSA) as the presenting problem in the each case vignette. A Pearson's product-moment correlation coefficient (*r*) was subsequently conducted for each of the case vignettes to determine if there was an association between measures of sexual attitude (as measured by SOS-R-M Total Scores) and psychologists perceptions of cybersex addiction as the presenting problem (as measured by CSA Subscale Scores). Table 5 outlines the findings from the alternative correlation analysis for Research Question 3.

Table 4

Research Question 3: Means and Standard Deviations for Psychologists' Perception of CSA as the Presenting Problem by Psychologist Sexual Attitude in All Three Cases of the CVSI-V3

		Sexual attitude^					
		Erotophobic (n = 46)		Erotophilic (n = 47)			
Variable	Case	*M*	*SD*	*M*	*SD*	*t*	*df*
Perception of CSA as the Presenting Problem±	Jeff	14.43	6.52	13.40	6.84	-0.74	91
	Sophie	23.35	3.80	23.21	4.77	-0.15	91
	Bill	24.67	3.06	23.98	4.82	-0.83	78.13

Note. ±The variable perception of CSA as the presenting problem is measured by the CVSI-V3 CSA Subscale Score; ^ The variable sexual attitude is based on the SOS-R-M Total Score.
*p < .10.

Table 5

Research Question 3: Summary of Correlations Between Psychologists' Sexual Attitude and Perception of CSA as the Presenting Problem for All Three Cases of the CVSI-V3

	Perception of CSA as the Presenting Problem±		
	Jeff	Sophie	Bill
Sexual attitude^	-0.02	+0.01	-0.005
n	93	93	93

Note. ±The variable perception of CSA as the presenting problem is measured by the CVSI-V3 CSA Subscale Score; ^ The variable sexual attitude is based on the SOS-R-M Total Score.
*p < .10.

Jeff. Results of a two-tailed independent samples *t*-test showed no significant difference between erotophilic and erotophobic sexual attitudes among psychologists (as measured by SOS-R-M Total Scores using the median as a cut-point) on psychologists' perceptions of CSA as the presenting problem in the case of Jeff (as measured by CSA Subscale Scores), $t(91) = -0.74$, $p > .10$. This analysis does not support there being a significant difference in mean CSA Subscale Scores for the case of Jeff between erotophobic and erotophilic psychologists.

Results of a Pearson's product-moment correlation coefficient (*r*) indicated no significant relationship in the case vignette of Jeff between measures of sexual attitude (as measured by SOS-R-M Total Scores) and psychologists perceptions of cybersex addiction (CSA) as the presenting problem (as measured by CSA Subscale Scores), $r(93) = -0.02$, $p > .10$.

Sophie. Results of a two-tailed independent samples *t*-test showed no significant difference in the case of Sophie between erotophilic and erotophobic sexual attitudes among psychologists (as measured by SOS-R-M Total Scores using the median as a cut-point) on psychologists' perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores), $t(91) = -0.15$, $p > .10$. As before with the case vignette of Jeff, this analysis does not support there being a significant difference in mean CSA Subscale Scores for the case of Sophie between erotophobic and erotophilic psychologists.

Results of a Pearson's product-moment correlation coefficient (*r*) conducted in the case vignette of Sophie indicated no significant relationship

between measures of sexual attitude (as measured by SOS-R-M Total Scores) and psychologists perceptions of cybersex addiction (CSA) as the presenting problem (as measured by CSA Subscale Scores), $r(93) = +0.01$, $p > .10$.

Bill. Results of a two-tailed independent samples *t*-test showed no significant difference in the case of Bill between erotophilic and erotophobic sexual attitudes among psychologists (as measured by SOS-R-M Total Scores using the median as a cut-point) on psychologists' perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores), $t(78.13) = -0.83$, $p > .10$. As was the case with the analyses conducted for the Sophie and Jeff case vignettes, this analysis does not support there being a significant difference in mean CSA Subscale Scores for the case of Bill between erotophobic and erotophilic psychologists.

Results of a Pearson's product-moment correlation coefficient (*r*) for the case vignette of Bill indicated no significant relationship between measures of sexual attitude (as measured by SOS-R-M Total Scores) and psychologists perceptions of cybersex addiction (CSA) as the presenting problem (as measured by CSA Subscale Scores), $r(93) = -0.005$, $p > .10$.

Research Question 4. The fourth research question explores whether there is a significant difference between participants' gender on their perceptions of cybersex addiction as the presenting problem in the client vignettes of the CVSI. A two-tailed independent samples *t*-test was conducted to evaluate if there would be a difference between Male and Female psychologists on their perception of cybersex addiction as the presenting problem (as measured by mean CSA

Subscale Scores) in each of the three case vignettes of the CVSI-V3. Table 6 outlines the findings for Research Question 4.

Table 6

Research Question 4: Means and Standard Deviations for Psychologists' Perception of CSA as the Presenting Problem by Psychologist Gender in All Three Cases of the CVSI-V3

		Gender					
		Female (n = 67)		Male (n = 26)			
Variable	Case	*M*	*SD*	*M*	*SD*	*t*	*df*
Perception of CSA as the Presenting Problem±	Jeff	13.64	6.68	14.62	6.72	0.63	91
	Sophie	23.67	3.95	22.27	5.02	-1.42	91
	Bill	24.70	3.62	23.35	4.92	-1.46	91

Note. ±The variable perception of CSA as the presenting problem is measured by the CVSI-V3 CSA Subscale Score.
*p < .10.

Jeff. Results showed there was no significant difference between male and female psychologists' on their perceptions of CSA as the presenting problem in the case of Jeff (as measured by CSA Subscale Scores), $t(91) = 0.63$, $p > .10$. This analysis does not support the notion of there being a significant difference between Male and Female psychologists in their perceptions of CSA as the presenting problem in the case vignette of Jeff.

Sophie. Results indicated there was no significant difference between male and female psychologists on psychologists' perceptions of CSA as the presenting problem in the case of Sophie (as measured by CSA Subscale Scores),

$t(91) = -1.42$, $p > .10$. This analysis does not support there being a significant difference between Male and Female psychologists in their perceptions of CSA as the presenting problem in the case vignette of Sophie.

Bill. Results showed no significant difference between male and female psychologists on psychologists' perceptions of CSA as the presenting problem, $t(91) = -1.46$, $p > .10$. This analysis does not support there being a significant difference between Male and Female psychologists in their perceptions of CSA as the presenting problem in the case vignette of Bill.

Research Question 5. The fifth research question asks if there is a significant difference between the provinces of registration of psychologists on their perception of the presenting problem of cybersex-addicted clients. Table 7 outlines the proportions of participants ($N = 93$) who endorsed registration in each of the various Canadian provinces and territories. The highest frequencies of registration were endorsed in Alberta, Ontario, and British Columbia, respectively.

Table 7

Frequency of Provinces and Regions of Registration

Province	Percent Endorsed	*n*	Region	Percent Endorsed	*n*
British Columbia (BC)	7.5%	7	West Coast	7.5%	7
Alberta (AB)	59.1%	55			
Saskatchewan (SK)	3.2%	3	Prairies	65.59%	61
Manitoba (MB)	3.2%	3			
Ontario (ON)	20.4%	19			
			Central	20.4%	19
Quebec (QC)	-	-			
Nova Scotia (NS)	3.2%	3			
New Brunswick (NB)	1.1%	1			
			Atlantic	5.38%	5
Prince Edwards Island (PEI)	-	-			
Newfoundland and Labrador (NL)	1.1%	1			
Northwest Territories (NWT)	1.1%	1			
Yukon (YT)	-	-	Northern	1.1%	1
Nunavut (NU)	-	-			

Note. $N = 93$.

A one-way ANOVA was conducted to determine if there was any difference between the participants' province of registration on their perceptions of CSA as the presenting problem (as measured by mean CSA Subscale Scores) in each of the three case vignettes. Post hoc analysis could not, however, be conducted at the provincial level due to at least one group having fewer than two cases (i.e., New Brunswick, Newfoundland and Labrador, and Northwest Territories). Table 8 outlines the findings of the provincial-level analysis for Research Question 5.

As a result a subsequent one-way ANOVA analysis was conducted at the regional level on participants' perceptions of CSA as the presenting problem (as measured by mean CSA Subscale Scores) in each of the three case vignettes with the removal of the Northwest Territories, which again presented as the only case in its group. Recoding the data on province of registration resulted in the proportions of participants (N = 93) registered in each region of Canada as outlined in Table 7. The highest regional frequencies of registration were endorsed in the Prairies and Central Canada, respectively. Table 9 outlines the findings of the regional-level analysis for Research Question 5.

Table 8

Research Question 5: Means and Standard Deviations for Psychologists' Perception of CSA as the Presenting Problem by Psychologist Province of Registration in All Three Cases of the CVSI-V3

	Perception of CSA as the Presenting Problem±					
	Jeff (*n* = 93)		Sophie (*n* = 93)		Bill (*n* = 93)	
Province	*M* *(SD)*	*F* *(df)*	*M* *(SD)*	*F* *(df)*	*M* *(SD)*	*F* *(df)*
		1.52 (8, 84)		1.11 (8, 84)		1.002 (8, 84)
British Columbia (BC)	12.43 (8.64)		22.43 (5.88)		23.57 (6.08)	
Alberta (AB)	15.09 (5.94)		23.75 (4.04)		24.69 (3.43)	
Saskatchewan (SK)	9.33 (4.16)		21.33 (3.79)		22.00 (3.61)	
Manitoba (MB)	10.33 (9.45)		18.33 (10.26)		19.33 (7.64)	
Ontario (ON)	11.89 (7.46)		23.58 (3.25)		24.37 (4.55)	
Nova Scotia (NS)	15.67 (0.58)		24.00 (2.65)		26.33 (1.16)	
New Brunswick (NB)	3.00 (-)		16.00 (-)		21.00 (-)	
Newfoundland and Labrador (NL)	24.00 (-)		25.00 (-)		26.00 (-)	
Northwest Territories (NWT)	18.00 (-)		22.00 (-)		26.00 (-)	

Note. ±The variable perception of CSA as the presenting problem is measured by the CVSI-V3 CSA Subscale Score.
*p < .10.

Table 9

Research Question 5: Means and Standard Deviations for Psychologists' Perception of CSA as the Presenting Problem by Psychologist Region of Registration in All Three Cases of the CVSI-V3

	Perception of CSA as the Presenting Problem±					
	Jeff (*n* = 92)		Sophie (*n* = 92)		Bill (*n* = ?)	
Region^	*M* (*SD*)	*F* (*df*)	*M* (*SD*)	*F* (*df*)	*M* (*SD*)	*F* (*df*)
		0.92 (3, 88)		0.16 (3, 88)		0.15 (3, 88)
West Coast (BC)	12.43 (8.64)		22.43 (5.88)		23.57 (6.08)	
Prairies (AB, SK, MB)	14.57 (6.16)		23.36 (4.51)		24.30 (3.82)	
Central (QC, ON)	11.89 (7.46)		23.58 (3.25)		24.37 (4.55)	
Atlantic (NL, PEI, NS, NB)	14.80 (7.53)		22.60 (4.16)		25.20 (2.49)	

Note. ±The variable perception of CSA as the presenting problem is measured by the CVSI-V3 CSA Subscale Score; ^ The variable of region does not include Northern Canada as it was represented by only one case.
*p < .10.

Jeff. The result of Levene's test of homogeneity of variance was significant ($p < .05$); however, a post-hoc analysis was not subsequently run due to there being less than two cases in three of the IV groups (NB, NL, and NWT). Results a one-way ANOVA indicated that there is no significant difference

between the nine provinces of registration (AB, BC, MB, NB, NL, NWT, NS, ON, and SK) on psychologists perceptions of CSA as the presenting problem, as measured by mean CSA Subscale Scores, in the case vignette of Jeff, $F(8, 84) = 1.52$, $p > .10$.

Results of a subsequent one-way ANOVA in the case of Jeff also indicated that there is no significant difference between the regions of Canada in which psychologists are registered (not including Northern Canada) on their perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores), $F(3, 88) = 0.92$, $p > .10$.

Sophie. The result of Levene's test of homogeneity of variance was significant ($p < .05$); however, a post-hoc analysis was not subsequently run due to there being less than two cases in three of the IV groups (NB, NL, and NWT). Results a one-way ANOVA indicated that there is no significant difference between the nine provinces of registration (AB, BC, MB, NB, NL, NWT, NS, ON, and SK) on psychologists perceptions of CSA as the presenting problem, as measured by mean CSA Subscale Scores, in the case vignette of Sophie, $F(8, 84) = 1.11$, $p > .10$.

Results of a subsequent one-way ANOVA in the case of Sophie indicated there is no significant difference between the regions of Canada in which psychologists are registered (not including Northern Canada) on their perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores), $F(3, 88) = 0.16$, $p > .10$.

Bill. The result of Levene's test of homogeneity of variance was not significant ($p > .05$); however, a post-hoc analysis was not subsequently run due to there being less than two cases in three of the IV groups (NB, NL, and NWT). Results a one-way ANOVA indicated that there is no significant difference between the nine provinces of registration (AB, BC, MB, NB, NL, NWT, NS, ON, and SK) on psychologists perceptions of CSA as the presenting problem, as measured by mean CSA Subscale Scores, in the case vignette of Bill, $F(8, 84) = 1.002$, $p > .10$.

Results of a subsequent one-way ANOVA in the case of Bill indicated there is no significant difference between the regions of Canada in which psychologists are registered (not including Northern Canada) on their perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores), $F(3, 88) = 0.15$, $p > .10$.

Research Question 6. The sixth and final research question asks if there is a significant difference between master's and doctoral level psychologists on their perception of cybersex addiction as the presenting problem in the client vignettes of the CVSI. A two-tailed independent samples *t*-test was conducted to evaluate if there would be a difference between Master's and Doctoral level psychologists on their perception of cybersex addiction as the presenting problem (as measured by mean CSA Subscale Scores) in each of the three case vignettes. Table 10 outlines the findings for Research Question 6.

Table 10

Research Question 6: Means and Standard Deviations for Psychologists' Perception of CSA as the Presenting Problem by Psychologist Highest Level of Education in All Three Cases of the CVSI-V3

		Highest Education Level					
		Master's (n = 38)		Doctoral (n = 55)			
Variable	Case	*M*	*SD*	*M*	*SD*	*t*	*df*
Perception of CSA as the Presenting Problem±	Jeff	15.34	6.45	12.93	6.69	1.74*	91
	Sophie	24.47	3.57	22.45	4.58	2.28**	91
	Bill	25.16	3.14	23.75	4.50	1.67*	91

Note. ±The variable perception of CSA as the presenting problem is measured by the CVSI-V3 CSA Subscale Score.
*p < .10. **p < .05.

Jeff. The results indicated there is a significant difference in the case of Jeff between master's and doctoral psychologists on psychologists' perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores) $t(91) = 1.74$, $p < 0.1$. This suggests that there is a significant difference in mean CSA Subscale Scores for the case of Jeff between Master's ($M = 15.34$, $SD = 6.45$) and Doctoral ($M = 12.93$, $SD = 6.69$) level psychologists. Specifically, Master's level psychologists perceptions were higher than those of Doctoral level psychologists.

Sophie. Results in the case of Sophie revealed a statistically significant difference between master's and doctoral psychologists on psychologists' perceptions of CSA as the presenting problem (as measured by CSA Subscale

Scores), $t(91) = 2.28$, $p < .05$. This suggests that for the case of Sophie there is a significant difference in mean CSA Subscale Scores between Master's (M = 24.47, SD = 3.57) and Doctoral (M = 22.45, SD = 4.58) level psychologists, with Master's level psychologists again posting higher scores than Doctoral level psychologists.

Bill. Results in the case of Bill showed a borderline significant difference between master's and doctoral psychologists on psychologists' perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores), $t(91) = 1.67$, $p = 0.1$. This suggests that for the case of Bill there is a significant difference in mean CSA Subscale Scores between Master's (M = 25.16, SD = 3.14) and Doctoral (M = 23.75, SD = 4.50) level psychologists. As was the case for the results concerning Sophie and Jeff, Master's level psychologists posted higher scores as compared to Doctoral level psychologists.

Additional Findings Related to Method

CVSI-V3 Question 1 by CVSI-V3 Question 2.

Jeff. A two-tailed independent samples *t*-test was conducted for the case of Jeff to ascertain if there a significant difference between those psychologists who selected cybersex addiction as the primary presenting problem vs. "Other" (CVSI-V3 Question 1) on their perception of cybersex addiction as the presenting problem, as measured by mean CSA Subscale Scores (CVSI-V3 Question 2) in the client vignette of Jeff. However, statistical analyses could not be performed, as there were zero cases identified for the category of CSA. This resulted in only

one group for the statistical analysis. The mean CSA Subscale Score for the remaining group, Other (N = 92), is 13.92 (SD = 6.70).

A subsequent and more clinically accurate recoding of the categories for Question 1 of the CVSI-V3 into "Either CSA or SA" and "Neither CSA nor SA" was done, and results of statistical analyses using this coding scheme showed a significant difference between those participants who selected "Either CSA or SA" (M = 18.67, SD = 3.50) as the primary presenting problem vs. "Neither CSA nor SA" (M = 13.59, SD = 6.76) on their perception of cybersex addiction as the presenting problem, as measured by mean CSA Subscale Scores (CVSI-V3 Question 2) in the client vignette of Jeff, $t(7.90) = 3.16$, $p < .05$.

Sophie. Results of a two-tailed independent samples t-test showed no significant difference between those psychologists who, on Question 1 of the CVSI-V3, selected cybersex addiction as the primary presenting problem (M = 24.55, SD = 2.66) vs. "Other" (M = 23.11, SD = 4.45) on their perception of cybersex addiction as the presenting problem, as measured by mean CSA Subscale Scores (CVSI-V3 Question 2) in the client vignette of Sophie, $t(91) = 1.04$, $p > .10$.

Results of a subsequent two-tailed independent samples t-test showed a significant difference between those participants who selected "Either CSA or SA" (M = 24.93, SD = 2.66) as the primary presenting problem vs. "Neither CSA nor SA" (M = 20.41, SD = 5.06) on their perception of cybersex addiction as the presenting problem, as measured by mean CSA Subscale Scores (CVSI-V3 Question 2) in the client vignette of Sophie, $t(43.68) = 4.83$, $p < .001$.

Bill. Results of a two-tailed independent samples *t*-test showed a significant difference between those psychologists who, on Question 1 of the CVSI-V3, selected cybersex addiction as the primary presenting problem (M = 25.45, SD = 2.71) vs. "Other" (M = 23.70, SD = 4.52) on their perception of cybersex addiction as the presenting problem, as measured by mean CSA Subscale Scores (CVSI-V3 Question 2) in the client vignette of Bill, $t(90.27) = 2.34$, $p < .05$.

Results of a subsequent two-tailed independent samples *t*-test showed a significant difference between those participants who selected "Either CSA or SA" (M = 25.04, SD = 3.22) as the primary presenting problem vs. "Neither CSA nor SA" (M = 23.38, SD = 4.81) on their perception of cybersex addiction as the presenting problem, as measured by mean CSA Subscale Scores (CVSI-V3 Question 2) in the client vignette of Bill, $t(64.25) = 1.89$, $p < 0.1$.

CVSI-V3 Question 1 by CVSI-V3 case order.

Jeff. A crosstabs analysis could not be conducted in the case of Jeff to examine the relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("CSA only" vs. "Other") and the CVSI-V3 case order they experienced (Jeff-Sophie-Bill vs. Bill-Sophie-Jeff) due to identification of the presenting problem being a constant with only one category (i.e., Other). Subsequent results of a 2x2 crosstabs showed a borderline significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("Either CSA or SA" vs. "Neither CSA nor SA") and the CVSI-V3 case order they experienced in the case

of Jeff (2x2 crosstabs; $p = .10$, two-tailed Fisher's exact test, Phi = -0.19). Among those participants who received the CVSI-V3 case order of Jeff-Sophie-Bill (low to high) 2.1% identified "Either CSA or SA" and 97.9% identified "Neither CSA nor SA" as the primary presenting problem for Jeff, whereas among those participants who received the CVSI-V3 case order of Bill-Sophie-Jeff (high to low) 11.4% identified "Either CSA or SA" and 88.6% identified "Neither CSA nor SA" as the primary presenting problem for Jeff.

Sophie. Results of a 2x2 crosstabs analysis indicated no significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("CSA only" vs. "Other") and the CVSI-V3 case order they experienced (Jeff-Sophie-Bill vs. Bill-Sophie-Jeff) in the case of Sophie, χ^2 (1, $n = 93$) = 0.60, $p > .10$. Subsequent results of a 2x2 crosstabs yielded no significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("Either CSA or SA" vs. "Neither CSA nor SA") and the CVSI-V3 case order they experienced in the case of Sophie, χ^2 (1, $n = 93$) = 0.68, $p > .10$.

Bill. Results of a 2x2 crosstabs analysis indicated no significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("CSA only" vs. "Other") and the CVSI-V3 case order they experienced (Jeff-Sophie-Bill vs. Bill-Sophie-Jeff) in the case of Bill, χ^2 (1, $n = 93$) = 2.46, $p > .10$. Subsequent results of a 2x2 crosstabs yielded no significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("Either CSA or SA"

vs. “Neither CSA nor SA”) and the CVSI-V3 case order they experienced in the case of Bill, χ^2 (1, n = 93) = 0.76, p > .10.

CVSI-V3 Question 2 by CVSI-V3 case order.

Jeff. A two-tailed independent samples *t*-test was conducted to ascertain if there was a difference in the case vignette of Jeff on psychologists’ perceptions of cybersex addiction (CSA) as the presenting problem, as measured by mean CSA Subscale Scores, between those who completed the CVSI-V3 measure in order of the case first that had the least number of CSA criteria (low-high; Jeff-Sophie-Bill) and the case first which had the most number of CSA criteria (high-low; Bill-Sophie-Jeff). Results indicated there is no significant difference for the case of Jeff between the mean CSA Subscale Scores of those who completed the cases in order from low to high (Jeff-Sophie-Bill; M = 13.49, SD = 6.23) as compared to high to low (Bill-Sophie-Jeff; M = 14.39, SD = 7.16), t(91) = -0.65, p > .10.

Sophie. Results of a two-tailed independent samples *t*-test showed no significant difference for the case of Sophie between the mean CSA Subscale Scores of those who completed the cases in order from low to high (Jeff-Sophie-Bill; M = 23.80, SD = 3.53) as compared to high to low (Bill-Sophie-Jeff; M = 22.70, SD = 4.99), t(91) = 1.23, p > .10.

Bill. Results of a two-tailed independent samples *t*-test showed a significant difference for the case of Bill between the mean CSA Subscale Scores of those who completed the cases in order from low to high (Jeff-Sophie-Bill; M

= 25.22, *SD* = 3.31) as compared to high to low (Bill-Sophie-Jeff; *M* = 23.32, *SD* = 4.56), $t(91) = 2.32$, $p < .05$.

CVSI-V3 Question 1 by survey completion method.

Jeff. A crosstabs analysis could not be conducted in the case of Jeff to examine the relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("CSA only" vs. "Other") and the survey completion method they used (online vs. mail) due to identification of the presenting problem being a constant with only one category (i.e., Other). Of those participants who selected Other (100%, *n* = 92) as the primary presenting problem in the case of Jeff, 51.1% completed the surveys online while 48.9% completed the surveys on paper by mail. Subsequent results of a 2x2 crosstabs showed no significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("Either CSA or SA" vs. "Neither CSA nor SA") and the survey completion method they used in the case of Jeff, χ^2 (1, $n = 92$) = 0.003, $p > .10$.

Sophie. Results of a 2x2 crosstabs analysis indicated no significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("CSA only" vs. "Other") and the survey completion method they used (online vs. mail) in the case of Sophie, χ^2 (1, $n = 93$) = 0.86, $p > .10$. Subsequent results of a 2x2 crosstabs also yielded no significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("Either CSA or SA" vs. "Neither CSA

nor SA") and the survey completion method they used in the case of Sophie, χ^2 (1, n = 93) = 0.01, p > .10.

Bill. Results of a 2x2 crosstabs yielded no significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("CSA only" vs. "Other") and the survey completion method they used (online vs. mail) in the case of Bill, χ^2 (1, n = 93) = 0.33, p > .10. Results of a subsequent 2x2 crosstabs analysis, however, did indicate a significant relationship between participants' identification of the primary presenting problem in need of therapeutic attention ("Either CSA or SA" vs. "Neither CSA nor SA") and the survey completion method they used (online vs. mail) in the case of Bill, χ^2 (1, n = 93) = 6.78, p < .01. Among those participants who completed the surveys online (n = 47), 70.2% identified the primary presenting problem as "Either CSA or SA" and 29.8% identified it as "Neither CSA nor SA" in the case of Bill. Among those participants who completed the surveys on paper by mail (n = 46), 43.5% identified the primary presenting problem as "Either CSA or SA" and 56.5% identified it as "Neither CSA nor SA" in the case of Bill.

CVSI-V3 Question 2 by survey completion method.

Jeff. Results of a two-tailed independent samples t-test in the case of Jeff showed a significant difference between perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores) of psychologists who participated in the study online (M = 12.45, SD = 6.86) as compared to those who participated by mail (M = 15.41, SD = 6.18), t(91) = -2.19, p < .05.

Sophie. Results of a two-tailed independent samples *t*-test in the case of Sophie showed no significant difference between perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores) of psychologists who participated in the study online ($M = 22.64$, $SD = 4.33$) as compared to those who participated by mail ($M = 23.93$, $SD = 4.20$), $t(91) = -1.47$, $p > .10$.

Bill. Results of a two-tailed independent samples *t*-test in the case of Bill showed no significant difference between perceptions of CSA as the presenting problem (as measured by CSA Subscale Scores) of psychologists who participated in the study online ($M = 23.72$, $SD = 4.54$) as compared to those who participated by mail ($M = 24.93$, $SD = 3.41$), $t(91) = -1.45$, $p > .10$.

Chapter 6 - Discussion

Mental health clinicians are dealing with a rapidly growing prevalence of clients presenting with cybersex addiction (Freeman-Longo, 2000; Young, 2001). Data indicates that greater than three-quarters of Canadians are using the Internet (Statistics Canada, 2010a), and 20% of all Internet users are engaging in online sexual activity (Cooper, Delmonico, & Burg, 2000). It has been said that the word "sex" is the most searched-for term on the Internet (Cooper, 1998; Freeman-Longo & Blanchard, 1998), and this is supported by estimates that 69% of all e-commerce by 1999 (Fisher & Barak, 2001) and more than 50% of all dollars spent online (Yoder, Virden III, & Amin, 2005; Cooper, Griffin-Shelley, Delmonico, & Mathy, 2001; Sprenger, 1999) involve the purchase of online sexual activities and materials.

Research indicates that 17% of those accessing online sexual content are experiencing problems with their online sexual behaviour, and 8% have been referred to in the literature as heavy users who spend between 11 to 80-plus hours per week online engaged in sexual activity and display online sexual compulsivity (Cooper, Scherer, Boies, & Gordon, 1999). These figures suggest that almost 2.7 million Canadians may be struggling with online sexual compulsivity. Unfortunately, due to the shame and denial inherent in cybersex addiction (Young, 1991; Reed, 2000; Adams & Robinson, 2001; Weiss, n.d.; Schwartz & Southern, 2000; Cooper, Putnam, Planchon, & Boies, 1999; Putnam, 2000; MacDonald, 1998; Adams & Robinson, 2001), cybersex addicts do not often voluntarily seek out therapy (Putnum & Maheu, 2000) and, even when they find

themselves in therapy (whether voluntarily for issues secondary to their acting out, or involuntarily), 20% do not tell their therapist about their problematic cybersex use (Cooper, Scherer, Boies, & Gordon, 1999; Goldberg, 2004).

Due to this disclosure avoidance, it is incumbent upon the mental health clinician to be more skilled and adept at identifying when the primary issue in need of therapeutic attention is indeed cybersex addiction (Delmonico, 2002). Research indicates that therapists' personal characteristics (Ayres & Haddock, 2009; Barry, 1999; Elkin, 1999; Hecker et al., 1995; Hersoug, 2004; Schover, 1981; Smith, 2003) can and do influence their diagnosis and treatment of clients, as well as the therapeutic outcome. This study was focused on determining whether therapists can indeed identify when the presenting problem is cybersex addiction. In addition, this study was intended to address to what degree, if any, personal and professional characteristics, including sexual attitudes, play a role in therapists' perceptions of the presenting problem among non-disclosing cybersex addicted clients.

In order to answer these questions a dependent measure called the Client Vignette Scoring Instrument (CVSI) was created and piloted in Phase I of this study, the results of which were presented and discussed earlier in Chapter 3. In Phase II of this study, 93 currently registered and practicing psychologists across Canada were recruited via mail and the Internet from the CPA and the PAA and their data were analyzed. The participants completed a series of questions in the CVSI-V3 about their perception of the main clinical issues in each of three fictional client case vignettes (Jeff, Sophie, and Bill), in addition to surveys about

their sexual attitudes, and their personal and professional demographic information. In the CVSI-V3, the case of Jeff included only one CSA symptom in its design, which was not enough to warrant an endorsement of CSA; the case of Sophie included three CSA symptoms in its design, which met the bare minimum necessary to warrant an endorsement of CSA; and the case of Bill included nine CSA symptoms in its design, which met the maximum number possible to warrant an endorsement of CSA. All three cases of Jeff, Sophie and Bill also included in their design the maximum possible number of symptoms for MDD and OCD and thus also warranted diagnostic endorsement of both, although secondary to the cybersex use in the cases of Sophie and Bill.

Discussion of Findings

Since this research was exploratory, there were no hypotheses to be substantiated. Overall, findings demonstrated that participants on the whole could tell when the client did not have a CSA as in the case of Jeff, but not when the client did as in the cases of Sophie and Bill; participants also displayed a tendency to over-perceive the presence (i.e., number) of CSA symptoms across all three cases, resulting in an overall tendency to inaccurately perceive Jeff as meeting and exceeding the minimum required number of criteria for endorsement of CSA.

Demographics. Roughly half of the sample completed the surveys online and the other half completed them by paper via mail. Close to half of the sample were CPA members and other approximately half were PAA members. The majority of the sample were registered in Alberta (59.1%), followed by Ontario (20.4%) and then British Columbia (3.2%), while the provinces least represented

were New Brunswick, Newfoundland and Labrador, and the Northwest Territories (1.1% each). Neither Prince Edward Island, Quebec, Nunavut nor Yukon Territory were represented in the final participant sample. Compared to 2009 Canadian Institute for Health Information statistics about healthcare providers, psychologists from Quebec make up the largest proportion of Canadian psychologists at 46.01%, while those from Alberta make up only 15.46% of the Canadian total, 20.20% come from Ontario, and 6.59% come from British Columbia (Canadian Institute for Health Information, n.d., p.198). Yukon Territory is not represented in the 2009 Canadian statistics as it did not regulate the profession of psychology at the time, and Newfoundland and Labrador (1.2%), Northwest Territories (0.50%), Prince Edward Island (0.20%) and Nunavut (0.12%) were among the provinces/territories with the smallest proportions of psychologists in Canada (Canadian Institute for Health Information, n.d., p.198). It should be noted, therefore, that psychologists from Alberta were overrepresented in this study's sample, as compared to the population of Canadian registered psychologists, while those from Quebec were significantly underrepresented as to be absent. A possible explanation for the overrepresentation of Alberta psychologists likely includes that the psychologists were directly recruited from the Psychologists Association of Alberta (PAA) via online flyer as well as via mail, whereas no such direct recruitment was done via professional voluntary membership organizations in other provinces. One possible explanation for the significant absence of registered psychologists from Quebec is that the surveys in this study were not translated into and provided in

French. Also, as compared to the Canadian population of registered psychologists, both British Columbia and New Brunswick were underrepresented by approximately half in this study's sample.

The median number of years in practice endorsed by the sample was 12 years and the mean was 14.99 years. This is similar to the mean number of years in practice reported for PAA members, which was 15 years (Petrovic-Poljak et al., 2010); however, CPA data on the same was not available. The majority of this study's sample endorsed specializing in working with adults (87.1%) and working in a private practice setting (65.6%). Again this is similar to the larger population of PAA members wherein more than half spent their time working with adults and the majority (41%) spent their time working in private practice (Petrovic-Poljak et al., 2010). Canada-wide information on these variables was not available, however, information from Service Canada indicates that 39.9% of Canadian psychologists are self-employed (Government of Canada, 2012), suggesting some type of private practice work.

The mean age of this study's sample was 47.63 years, and most identified themselves ethnically as Canadian (80.6%), reporting a mean of 43.87 years lived in Canada. Similarly, the average age of Canadian registered psychologists is 45 years (Canadian Institute for Health Information, 2006, p. 197) and the majority (52%) of registered psychologists in Canada fell between 45 to 64 years of age (Government of Canada, 2012). Other notable characteristics related to this study's sample included that the majority of participants were heterosexual (69.9%), in a relationship (78.5%), relatively erotophilic (scoring a mean of 79.72

on a scale of 0 to 126), and female (72%). Additionally, participants typically self-identified as comfortable using both the computer and the Internet (a mean of 4, where 5 meant “extremely comfortable”), and the majority held a doctoral degree (59.1%) and reported having had little to no training in SA/CSA (62.7%).

Gender and highest level of education are the only comparable data available for the population of registered psychologists. Sixty-five percent of CPA members (CPA, 2012), 68% of PAA members, 70% of CAP members (Petrovic-Poljak et al., 2010), and 74.6% of Canada-wide registered psychologists (Government of Canada, 2012) are female. However, unlike this study’s sample, while the majority of CPA members have either a Master's or a doctoral degree (65%; CPA, 2012), 67% of CAP members hold Master's degrees, and 62% of PAA members hold Master's degrees (Petrovic-Poljak et al., 2010). It should be noted, however, that among PAA members 50% of registered psychologists aged 55 or older do hold doctoral degrees (Petrovic-Poljak et al., 2010), which may explain the higher proportion of participants in this study holding doctoral degrees given the higher representation of psychologists from Alberta and the mean age of the sample.

Theoretical framework for understanding findings. Identifying a theoretical framework that could possibly explain the varied, complex, and at times counter-intuitive findings from this research, proved challenging. The theoretical framework had to be able to suggest possible explanations not only for why significant results were found, but also for why non-significant results existed. In addition to this, despite the fact that the three cases were never

intended to be directly comparable to each other due to variations in client characteristics, the theoretical framework had to encapsulate both (a) why participants appeared to be able to discern the absence of a cybersex addiction as a diagnostic category accurately but then unable to discern it's presence, as well as (b) why participants seemed to over-perceive cybersex addiction symptoms in all cases, resulting in a positive endorsement of cybersex addiction across all three cases, including the one that they had accurately ascertained earlier should not be given a sex or cybersex addiction diagnostic label. Finally, the theoretical framework chosen also had to suggest a possible explanation for why participants' measured personal characteristics did not result in significant findings (i.e., sexual attitude, Internet familiarity and age, with the exception of the latter in the case of Jeff), and some of their professional characteristics resulted in non-significant findings (i.e., province/region of registration, number of years of practice and amount of training in sex/cybersex addiction), while other professional characteristics resulted in significant findings (i.e., highest education level).

The theoretical framework selectively proposed herein is that of the dual-system model of thinking - more specifically within it, the interacting constructs of expertise and judgement heuristics (Kahneman, 2011; Tversky & Kahneman, 1974). Recognizing that both fields individually are vast, and that an in-depth discussion of each is beyond the scope of this research and this chapter, this author proposes the possibility that in the absence of the former (expertise) the latter (judgement heuristics) may have played a role in the results found. Briefly,

I will expound upon both here and then will discuss the implications of each for the research questions in turn.

Kahneman (2011), a leading psychologist in behavioural economics, has proposed that there are two systems at work in our thinking. The first he dubbed System 1 and it refers to the quick, automatic, least effort thinking that relies on patterns and recognition in the data when making decisions (Kahneman, 2011). The second he labelled System 2 and it refers to the slow and effortful type of thinking that requires attention and concentration (Kahneman, 2011). System 1 thinking has been described as the type of thinking required to drive down a familiar empty highway in good weather, while System 2 has been described as the type of thinking required to drive on an unfamiliar, icy, single-lane highway in bad weather while trying to pass a truck (Babetski, 2012; Kahneman, 2011).

Kahneman (2011) asserted that while we like to think that our decisions and judgements are being made from a System 2 type of thinking, in reality most of our decisions are guided by System 1, and indeed he went so far as to add that System 1 invariably influences System 2. He indicated that System 1 produces "feelings and impressions" (Babetski, 2012, p. 2; Kahneman, 2011) which inform the "explicit beliefs and deliberate choices" (Babetski, 2012, p. 2; Kahneman, 2011) then produced by System 2. Kahneman (2011) argued that due to evolutionary adaptation towards economy of thought, humans operate most of the time in System 1 thinking, indicating a tendency towards laziness of thought as System 2 is inactive. The weaknesses of System 1 are that it is inclined to making predictable errors in certain situations (which include biases) and that shutting it

off is not possible (Kahneman, 2011). The weakness of System 2 is that, while it can with some mental exertion override the biases produced by System 1, it generally is notably ineffective at catching the biased thinking in the first place, and requires too much energy to keep engaged (Kahneman, 2011).

These weaknesses of System 1 and System 2 thinking are outlined in detail in Kahneman's (2011) discussion of intuition and expertise. He argued that intuition informed by bias, though often invalid, can appear very similar to valid and credible intuition that is informed by true expertise (Babateski, 2012; Kahneman, 2011). He claimed that when an individual without expertise in a certain area is exposed to a problem, the tendency is to default to the most economical, least effortful attempt to solve the problem (System 1), using various judgement heuristics (i.e., biases) (Kahneman, 2011). However, he stated that when an expert is presented with a problem within his/her domain of expertise, the development of said expertise has resulted in a coding of patterns and templates for making sense of the problem such that, what may have started off as a System 2 process, is now encoded in System 1 and its retrieval is fast, automatic, overrides bias tendencies normative to System 1, and can be trusted more readily as valid (Kahneman, 2011).

Two types of judgment heuristics (biases) common in System 1 thinking among non-experts are the representativeness heuristic and the availability heuristic (Garb, 2005; Kahneman, 2011; Tversky & Kahneman, 1974). The representativeness heuristic is a type of biased System 1 thinking in which "probabilities are evaluated by the degree to which A is representative of B, that

is, by the degree to which A resembles B" (Tversky & Kahneman, 1974, p. 1124). A clinical example of this might be when "a single, female executive in her mid-30's" engaging in increased sexual behaviour (as in the CVSI-V3 case of Sophie) is dubbed as more disturbed than a "married, male neurologist in his mid-40's" (as in the CVSI-V3 case of Jeff) or a "married, male electrician in his mid-20's" (as in the CVSI-V3 case of Bill) engaging in the same, due to pre-existing gender stereotypes held about women and sexuality. In reality, these descriptions do not provide us with enough information to make such a decision; however, depending on how strong the stereotype, it may override any other information provided. (Garb, 1996, 1997, 2005; Ford & Widiger, 1989; Hecker et al., 1995; Pavkov, Lewis, & Lyons, 1989).

The availability heuristic, also a type of biased System 1 thinking, is described as what happens when "people assess the frequency of a class or the probability of an event by the ease with which instances or occurrences can be brought to mind" (Tversky & Kahneman, 1974, p. 1127). A clinical example of this might be when reactions to a married male partner semi-frequently accessing online sex (as in the CVSI-V3 case of Jeff), or masturbating daily and accessing increasingly interactive online sex that never progresses offline (as in the CVSI-V3 case of Bill), involve greater normalization and less pathologizing than reactions to a female who ends her engagement due to frequent offline high risk casual sex with men she met online (as in the CVSI-V3 case of Sophie). This may be due to the relative ease with which most of us can recall relatively recent examples from TV or real life in which men access online sex even within a

marriage. Examples of women ending serious relationships, however, due to a need for high risk offline sex that derived from online access is not something most can easily recall having encountered recently. In reality, none of these circumstances provides enough information by itself to calculate the probability of a true pathology existing. However, as indicated earlier, this study did not include collection and analysis of data related to the characteristics of the client in the case vignette due to time and financial constraints.

On the other hand, according to the literature, expertise is the development of a knowledge base or skill as a direct result of the interaction of time and deliberate practice (Ericsson, 2004, 2006). Time here refers to length of exposure and is best achieved in an "environment that is sufficiently regular to be predictable" (Babetski, 2012, p. 4; Kahneman, 2011, p. 238). Deliberate practice can be further broken down into experience paired with feedback (the more immediate the better), and experience refers to formal training and content of exposure (Ericsson, 2004, 2006). Feedback refers to receiving prompt and clear information about the consequences of one's decisions, thereby reinforcing them as correct or indicating further adjustment is needed (Garb, 2005; Kahneman, 2011; Spengler et al., 2009). Research indicates that individual characteristics do not limit the development of expertise (with the exception of body height and size in certain athletics) where the other components of expertise are present (Ericsson, 2004; Ericsson, Krampe, & Tesch-Romer, 1993). In terms of sex or cybersex addiction, the implications are that expertise develops from seeing many clients with this presenting concern over a long period of time in an environment that

provides opportunity for repeated practice, supervision, and prompt feedback combined with training. With true expertise in sex/cybersex addiction, it is postulated that biases of System 1 thinking are made conscious and held in check (Kahneman, 2011). The question asked of participants in this research was how much training they had completed in sex/cybersex addiction, and in response the majority endorsed having had little to none, while no information was collected about the number of clients seen with this issue, the duration over which those clients were seen, and whether supervision and feedback regarding their treatment of such clients were components of their (deliberate) practice.

To summarize, as per the dual-system model of thinking, when true expertise in sex/cybersex addiction exists we can trust that the judgements made are free from bias. However, when no true expertise exists in sex/cybersex addiction it can be assumed that if System 2 thinking was accessed, it would have required pre-existing knowledge about the disorder, was done so for short periods, and was likely influenced or overridden by System 1 thinking that was likely shaped by judgement heuristics, such as representativeness and availability.

The findings from each of the research questions is discussed below in greater detail. Implications for future research are discussed for each research question, however, a more extensive discussion of suggestions and implications for future research can be found at the end of this chapter in a separate section.

Research Question 1. The purpose of the first research question was to determine whether cybersex addiction was selected by psychologists more often than other categories in their identification of the presenting problem in the client

vignettes of the CVSI. Results for this research question were mixed. Findings indicated that all participating psychologists were able to accurately pinpoint when CSA was not the primary presenting problem (in the case of Jeff), but most were not able to do so when CSA was the primary presenting problem (in the cases of Sophie and Bill). Put simply, most psychologists could tell when the client did not have a CSA, but not when the client did.

The simplest possible explanation for this finding is that participants lacked the appropriate expertise to determine whether the clients in the case vignettes had cybersex addiction. Indeed, the majority of participants indicated that they had little-to-no training (only one component of expertise) in sex/cybersex addiction. According to the framework presented, training is a necessary but not solely sufficient component of expertise (Ericsson, 2006; Kahneman, 2011). As a result, it is possible that participants may have had difficulty accepting or believing the notion that sexual activity on the Internet could lead to the types of issues that Sophie and Bill were experiencing. In the case of Jeff, it is possible that participants were simply continuing that trend, rather than astutely determining that Jeff was free from the disorder. While the possibility was considered that participants may have been unwilling to provide a diagnostic label that is, as yet, not recognized by the DSM, results from the combining of sex addition and cybersex addiction categories (below) suggest otherwise, ruling out inclusion in the DSM as an influencer. Further research is needed to determine specifically if and what components of expertise suggested in the literature (Ericsson, 2006; Kahneman, 2011) might be necessary or sufficient

in order to be able to accurately identify the presence of cybersex addiction as the presenting problem among clients. In addition, further research is warranted to identify pre-existing assumptions that non-experts in cybersex addiction may unwittingly hold about the type of acting out behaviour that can be problematic online.

Once adjustments was made for a more clinically accurate picture in which the broader category of SA was coupled with CSA the results appeared even more convoluted. Findings indicated that most participating psychologists maintained their ability to accurately identify when "Neither CSA nor SA" were the primary presenting problem (in the case of Jeff). Most psychologists were also now able to accurately identify when "Either CSA or SA" was the primary presenting problem with a minimum number of CSA symptoms built into the case (as with Sophie). However, while more psychologists were able to accurately identify when "Either CSA or SA" was the primary presenting problem with the maximum number of CSA symptoms built into the case (as with Bill), they did not pose a significant majority. Again, put simply, most psychologists could tell when the client had neither CSA nor SA, as well as when the client had either CSA or SA with a minimum of CSA symptoms. However, when the client had a maximum of CSA symptoms those psychologists who could tell that either CSA or SA was indeed present didn't differ significantly in proportion from those who couldn't. It appears as though the fewer CSA symptoms participants were encountering, the more consensus they displayed as a group about whether the client had "Either CSA or SA" or not. Conversely, the more CSA symptoms

participants encountered, it appears the less consensus they displayed as a group about whether the client had “Either CSA or SA” or not.

Initial perceptions of this result seemed counterintuitive, as participants who were reluctant to use the label of cybersex addiction, on re-analysis suddenly seemed open to using the label of sex addiction when it came to the case of Sophie. Again, it's possible that a lack of expertise among participants in the field of sex/cybersex addiction might provide a possible explanation for these findings. As discussed earlier, the literature on expertise suggests that when expertise in a particular topic is lacking, individuals tend to automatically make use of System 1 judgement heuristics in attempting to solve the problem before them (Kahneman, 2011). In the case of Sophie, and in the absence of expertise in sex/cybersex addiction, it is possible that representativeness and availability heuristics (biases) about women and sexuality and the frequency of the nature of the sexual activity engaged in may have resulted in a tendency on the part of participants to label Sophie as more pathological regarding her sexual behaviour than either Bill or Jeff (see Garb, 1997). This finding is in line with that of Hecker et al. (1995), in which single clients with multiple sexual partners (offline) were pathologized more often and were more likely to be labelled as having a sex addiction when compared to married monogamous clients, regardless of the client's gender. Despite the nature of their online sexual behaviour, both Jeff and Bill may still be perceived by some clinicians as monogamous in their marriages as their behaviour did not proceed offline, whereas unmarried Sophie's behaviour did proceed offline with multiple sexual partners, possibly contributing to this study's

finding. Further research would be necessary to determine if indeed representativeness and availability heuristics play a role in the identification of cybersex addiction as the presenting problem among non-experts as compared to experts in the field of sex/cybersex addiction.

Research Question 2a. The purpose of part one of the second research question was to determine if there was a relationship among psychologists between their personal and professional characteristics (specifically age, number of years of practice, Internet familiarity, cybersex addiction familiarity, and sexual attitude) and their perception of the presenting problem as cybersex addiction in the client vignettes of the CVSI. Results for this research question were all non-significant and did not support the existence of a predictive relationship in any of the case vignettes of Jeff, Sophie or Bill. Findings showed that psychologists' personal and professional characteristics of age, number of years in practice, Internet familiarity, CSA familiarity, and sexual attitude did not have a predictive relationship with their tendency to perceive CSA as the presenting problem across the board in each of the cases. Put another way, it did not appear to matter what age psychologists were, nor how long they had been practicing, how comfortable they were with using the Internet, how much training they had received in SA/CSA, nor their sexual attitudes when it came to their tendency to perceive CSA as the presenting problem in each of the case vignettes.

As indicated earlier, the research surrounding expertise suggests that personal characteristics do not influence its development (unless athletically necessary; Ericsson, 2004; Ericsson et al., 1993). According to the literature,

expertise is an outcome of time in interaction with deliberate practice, which is composed of experience and feedback (Ericsson 2004, 2006; Ericsson et al., 1993). Through this framework, and based on data indicating a lack of training in sex/cybersex addiction among the participants, it may not be surprising then that the predictive model tested did not prove significant for each of the cases. The predictor variables that made up the model tested were composed of age, sexual attitude, Internet familiarity, number of years in practice, and amount of training in sex/cybersex addiction (i.e., CSA familiarity). Since age, sexual attitude, and Internet familiarity are considered personal variables, and personal variables are not considered to play a role in expertise according to the expertise literature (Ericsson, 2004; Ericsson et al., 1993), this may explain why the inclusion of these variables in the model did not lend to its predictability in the cases into which sex/cybersex addiction were actually built (Sophie and Bill). The finding that sexual attitude did not influence participants' perception of cybersex addiction as the presenting problem is unexpected given the findings of Ayres and Haddock (2009), in which a negative attitude towards pornography among therapists was shown to be associated with a likelihood of perceiving pornography as problematic and possibly an indication of sex addiction, albeit in response to a married male client presenting for couples therapy.

The above considered framework of expertise (Ericsson, 2006; Kahneman, 2011) may also explain why the remaining professional variables of number of years in practice and amount of training in sex/cybersex addiction did not lend to the predictability of the model as neither seems to reflect in whole the

requirements for expertise. Whereas number of years in practice reflects the passage of time, it does not suggest passage of time exposed in practice to specifically sex/cybersex addiction (duration of exposure). However, this finding is out of alignment with the results of the meta-analysis conducted by Spengler et al. (2009), which found that in general clinical judgement accuracy (including diagnostic) improved by almost 13% with clinician experience, either educational or clinical.

Furthermore, whereas amount of training in sex/cybersex addiction reflects a portion of a component of expertise (i.e., experience in deliberate practice), it does not address the important components of supervision, number of real clients with sex/cybersex addiction encountered in practice, and feedback. Contrary to previous findings by Spengler et al. (2009), this finding is in line with that of Ayres and Haddock (2009) in that their results also showed no association between amount of training (albeit at the graduate level) in pornography and therapists inclination to assess for sex addiction (suggesting perception of sex addiction as a possible presenting problem) in a client (albeit married male) displaying problematic use of online pornography. In addition, Ayres and Haddock (2009) found no association either between therapists' familiarity with the literature on pornography and their inclination to assess for (and thus potentially perceive) sex addiction as the problem. Again, the majority of participants in this study indicated that they had little-to-no training in sex/cybersex addiction, which is similar to those therapists surveyed by Ayres and Haddock (2009).

According to the framework presented, duration of exposure (i.e., time) and training are necessary, but not sufficient, components of expertise (Ericsson, 2004, 2006). Therefore, it is postulated that the elements of expertise may possibly have been contained in part in the predictive model tested, but not in whole, suggesting a possible explanation for why the model did not prove significant overall. Further research is needed to clearly determine if inclusion of measures of all the components of expertise in a model would successfully predict perceptions of cybersex addiction as the presenting problem among recognized and/or certified experts in the field of sex/cybersex addiction.

Research Question 2b. The purpose of part two of the second research question was to determine if there was a significant relationship between psychologists' age and their perception of cybersex addiction as the presenting problem in the client vignettes of the CVSI. Results for this research question were mixed. Findings indicated that there was a weak positive relationship between psychologists' age and their perception of CSA as the presenting problem in their responses to the case of Jeff, but that no significant relationship existed in the cases of Sophie or Bill. Essentially, the age of the psychologists didn't seem to play a role when it came to their tendency to perceive CSA as the presenting problem among clients, unless the client didn't have CSA and then psychologists displayed a small increase in tendency to perceive CSA as they, the psychologists, increased in age.

Again, research suggests that personal characteristics (such as age) do not influence the development of expertise, which instead results from time in

interaction with deliberate practice (Ericsson, 2004; Ericsson et al., 1993). The longer one is in practice as a psychologist, theoretically the more clients one is exposed to overall, which by default increases the number of clients one is likely to encounter with sex/cybersex addiction symptoms. This, however, is not enough by itself to develop expertise in sex/cybersex addiction as such clients may not have been seen in a regular and predictable manner (Kahneman, 2011), with feedback, and with sufficient frequency/recurrence to be able to implement that feedback (Ericsson, 2006; Kahneman, 2011). The fact that a measure of time (i.e., the variable age) appeared to correlate with perception of cybersex addiction as the presenting problem for the case in which cybersex addiction was not built in is possibly understood when time is thought of as the component of expertise that does not assume deliberate practice. It also possibly explains why age did not correlate with perceptions of cybersex addiction as the presenting problem in the cases in which sex/cybersex addiction criteria were actually built in (Sophie and Bill). The cases of Sophie and Bill would have required less exposure to number of clients across the lifespan of practice to discern that there were sex/cybersex addiction symptoms at play given the type of acting out seen in Sophie and the sheer number of symptoms seen in Bill. It can be theorized then that age (i.e., time) may possibly play a role in participants being able to discern that there were sexual concerns in the case of Jeff; however, without true expertise in sex/cybersex addiction (including deliberate practice), they were unable to discern this clearly and to what degree (if any) it suggested cybersex addiction, resulting in the weak nature of the correlation. This finding is in line with the results of the

meta-analysis conducted by Spengler et al. (2009), which identified an improvement in general clinical judgement accuracy (including diagnostic) by almost 13% with clinician experience (i.e., educational or clinical), and one could assume that clinical experience would correlate to some extent with age. Again, it is also possible that, in the absence of true expertise in sex/cybersex addiction, participants may have been guided by judgement heuristics that somehow correlated with participant age. Further research is needed to determine the relationship between age and use of judgement heuristics among clinicians, as well as between number of clients with cybersex addiction seen in the lifespan of practice and accuracy in diagnosing this issue.

Research Question 3. The purpose of the third research question was to determine if there was a significant difference between erotophilic and erotophobic psychologists on their perception of cybersex addiction as the presenting problem in the client vignettes of the CVSI. An alternative version of this question examined whether there was a significant relationship between psychologists' sexual attitude and their perceptions of CSA as the presenting problem in each case vignette. Results across all three cases of Jeff, Sophie and Bill were consistent and showed no significant difference between erotophilic and erotophobic psychologists on their tendency to perceive CSA as the presenting problem. Further, there was no significant relationship between psychologists' sexual attitude and their tendency to perceive CSA as the presenting problem in any of the case vignettes. Simply put, regardless of how many CSA symptoms a client has, it doesn't seem to make a difference what sexual attitude a

psychologist has when it comes to their tendency to perceive CSA as the presenting problem.

Findings for this research question were surprising. Previous research findings had suggested an inverse association between therapist sexual attitude (as measured by attitudes towards pornography) and their perception of online pornography as problematic and warranting assessment for sex addiction (albeit among married male clients; Ayres & Haddock, 2009). The participants in this sample were relatively erotophilic, which may have been in part due to the professional identities they referenced when completing the CVSI-V3 and carried over to completing the SOS-R-M. Positive sexual attitudes among participants also may be due in part to the group being of higher socioeconomic status, which has been found to be positively correlated with sexual attitude (Gilbert & Gamache, 1984), and which tends to be associated with higher education level.

However, as outlined earlier, the expertise literature suggests that personal characteristics, like sexual attitude, do not influence the development of expertise (Ericsson, 2004; Ericsson et al., 1993). Again, expertise is suggested to come from time combined with deliberate practice (Ericsson, 2004, 2006). Because personal characteristics are not considered a component of expertise, this may possibly explain why sexual attitude did not appear to have a significant effect on psychologists' perceptions of cybersex addition as the presenting problem in any of the cases. Further research is needed to replicate this finding more directly and clearly through examining the relationship between sexual attitude and all the components proposed in the literature for expertise in sex/cybersex addiction.

Research Question 4. The fourth research question explored whether there was a significant difference between participants' gender on their perceptions of cybersex addiction as the presenting problem in the client vignettes of the CVSI. As with sexual attitude, results across all three cases of Jeff, Sophie and Bill were consistent and showed no significant difference between male and female psychologists on their tendency to perceive CSA as the presenting problem. The gender of the participants did not seem to play a role in psychologists' tendency to perceive CSA as the presenting problem in clients.

Again, as with Research Question 3, findings for this research question were surprising. Previous research had suggested a connection between therapist gender and perception of sexual problems among clients (Hecker et al., 1995). Unlike the findings of Hecker et al. (1995), in which male therapists were more likely than female therapists to label hypersexual married monogamous and single multi-partnered male and female clients in case vignettes as sexually addicted, this study found no such association. However, again as indicated earlier, the literature on expertise suggests that personal characteristics, like gender, do not play a role in the development of expertise (Ericsson, 2004; Ericsson et al., 1993), because expertise is the outcome of time combined with deliberate practice (Ericsson, 2004, 2006). Because it is not a component of expertise, this may explain why psychologists' gender did not appear to have an effect on their perceptions of cybersex addiction as the presenting problem in any of the cases.

Research Question 5. The purpose of the fifth research question was to determine if there was a significant difference between psychologists' province of

registration on their perception of cybersex addiction as the presenting problem in the client vignettes of the CVSI. A subsequent analyses was conducted to examine whether there was a difference between psychologist region of registration on their perception of CSA as the presenting problem in response to the cases of the CVSI. Findings indicated no significant difference between provinces of registration or regions of registration on psychologists' tendency to perceive CSA as the presenting problem in any of the cases. Put another way, it doesn't seem to matter where psychologists are registered (and by extension, one would assume, practicing and living) in Canada when it comes to their perception of CSA as the presenting problem.

Findings indicated that the majority of participating psychologists were registered (and presumably practicing) in the Prairies (particularly Alberta), followed by Central Canada (specifically Ontario). Where one is registered and practices is likely a reflection of where they reside if they are currently practicing (as per the screening criteria for this study). Again, as with age, gender and sexual attitude, research on expertise suggests that where one resides should not impact their ability to attain expertise in sex/cybersex addiction (Ericsson, 2004; Ericsson et al., 1993). If expertise is composed, again, of time in combination with deliberate practice (Ericsson, 2004, 2006), and we have no information to suggest that sex/cybersex addiction is limited to certain geographic areas within Canada or North America (indeed it is highly unlikely to be so), then this may possibly explain why province or region of registration did not seem to influence perception of sex/cybersex addiction as the presenting problem across all the

cases. Further research may be needed to ascertain whether clients with sex/cybersex addiction do indeed vary in proportion across the provinces or regions of Canada and, if so, to what this may be attributed.

Research Question 6. The purpose of the sixth and final research question was to determine if there was a significant difference between master's and doctoral level psychologists on their perception of cybersex addiction as the presenting problem in the client vignettes of the CVSI. Results were unanimous that psychologists' highest level of education did make a significant difference in their tendency to perceive CSA as the presenting problem across all three case vignettes of the CVSI. Findings indicated that having a doctoral degree led to a significantly lower, and as a result more accurate, perception of CSA as the presenting problem across all three cases. Put simply, the more educated psychologists were the more conservative, and thus more accurate, they were in their perceptions of CSA as the presenting problem with clients who both do and do not have CSA.

Making sense of the findings for this research question proved challenging. The majority of participants in the sample had attained a Doctoral degree as their highest level of education. It is also important to note here that participants with Doctoral and Master's degrees tended to similarly over-perceive the number of cybersex addiction symptom criteria present in each case, and also to similarly endorse all case vignettes as meeting minimum criteria for diagnosis of cybersex addiction, even though this was not the case for Jeff. This finding is in line with previous meta-analysis results that indicate general clinical judgement accuracy

improves by approximately 13% with clinician education or clinical experience (Spengler et al., 2009).

At the time data were collected, individuals in the only provinces/territories of Alberta (AB), Saskatchewan (SK), Newfoundland and Labrador (NL), Northwest Territories (NWT), Nunavut (NU), Nova Scotia (NS), and New Brunswick (NB) were allowed to apply for and attain full registration as Psychologists in independent practice with only a Master's degree as highest education level completed (Canadian Psychological Association, 2009). In this study, participants from these specific provinces made up the majority of the sample at 68.8%. Completion of a Doctoral degree usually involves the completion of additional supervised practicum hours beyond those attained in a Master's degree, in addition to a minimum number of supervised hours of practice required for registration. Regarding the latter, of the provinces that did permit full registration as a psychologist at a Master's level at the time of data collection, all except NL, NS, and NB required only 1500-1600 hours of supervised practice for registration post-Master's degree (Canadian Psychological Association, 2009). This suggests that even those participating Master's-level psychologists who had been practicing in the field for the same amount of time as their Doctoral-level colleagues would likely have been doing so having completed less supervised practice overall. Less exposure to supervised practice suggests less feedback experience.

Turning again to the literature on expertise, we are reminded that expertise is the result of time combined with deliberate practice (Ericsson, 2004, 2006).

Deliberate practice is defined as a combination of experience (i.e., content of exposure, training, and number of clients encountered in a regular and predictable environment) and feedback (i.e., from supervisors and from clients in a prompt fashion) (Ericsson, 2006; Garb, 2005; Kahneman, 2011; Spengler et al., 2009). The presence of feedback may allow for improvement of accuracy in clinical judgement, as well as possibly give exposure to the limitations of one's knowledge and skill base. Increased exposure to the limitations of one's own knowledge and skill may lead to more cautious clinical judgements and assessments.

It is possible then that this component of increased exposure to supervised practice, and hence feedback, may explain the increased cautiousness among Doctoral-level participants when compared to Master's-level participants in their perceptions of cybersex symptom criteria. The reduced exposure to supervised practice (i.e., feedback) among Master's-level participants may also suggest an increased tendency to be influenced by judgement heuristics in their perceptions of cybersex symptom criteria.

Again, as indicated earlier, further research is needed to clearly determine if inclusion of measures of all the components of expertise would successfully influence perceptions of cybersex addiction as the presenting problem among recognized and/or certified experts in the field of sex/cybersex addiction and differentiate them from non-experts. Also, further research is warranted that explores whether the differences between Master's- and Doctoral-level psychologists remain even when all the components of true expertise in

sex/cybersex addiction are studied. Furthermore, additional research is needed to ascertain if increased access to supervised practice reduces reliance on judgment heuristics and if the corollary is also the case.

Additional Findings Related to Method.

Relationship between Question 1 and Question 2 of the dependent measure (CVSI-V3). Again, as indicated earlier, in all cases (Jeff, Sophie and Bill) psychologists tended to over-perceive the presence of CSA symptoms relative to what was actually built into the design of the case and, in the case of Jeff, beyond what was required to endorse the diagnosis of CSA. An examination of participants' tendency to perceive CSA symptoms (Question 2 of the CVSI-V3) by their actual identification of CSA as the primary presenting problem (Question 1 of the CVSI-V3) revealed mixed findings. Psychologists unanimously identified the client without CSA (Jeff) as having a primary presenting problem as something other than CSA, but perceived that same client as having enough CSA symptoms to meet the diagnosis of CSA. When the client had the maximum CSA symptoms (Bill), psychologists who identified CSA as the primary presenting problem not surprisingly had a significantly higher perception of CSA symptoms than those who did not. However, when the client had a minimum of CSA symptoms (Sophie), psychologists who identified the client as having CSA as the primary presenting problem did not differ significantly in their perception of CSA symptoms from those who identified something else as the primary presenting problem.

A subsequent examination of psychologists' tendency to perceive CSA symptoms by their identification of the primary presenting problem as "Either CSA or SA" or "Neither CSA nor SA" were consistent. In all three client cases, psychologists who identified the primary presenting problem as "Neither CSA nor SA" not surprisingly perceived the client as having significantly less CSA symptoms (but still more than that which was built into the case and, in the case of Jeff, more than was required to endorse the diagnosis of CSA) as compared to those who identified the client's primary presenting problem as "Either CSA or SA."

Effects of case order on Question 1 and Question 2 of the dependent measure (CVSI-V3). An examination of the effects of case order in the dependent measure (the CVSI-V3) on participants' identification of CSA (or "Either CSA or SA") as the primary presenting problem (Question 1 of the CVSI-V3) and on their tendency to perceive CSA symptoms (Question 2 of the CVSI-V3) yielded mixed findings. While case order did not appear to significantly influence whether participants identified the primary presenting problem as "CSA only" or "Either CSA or SA" in response to the cases of both Sophie and Bill, it did seem to make a significant difference in their responses to the case of Jeff. Of those participants who received the case order of Bill-Sophie-Jeff (high to low) a significantly larger proportion identified "Either CSA or SA" as the primary presenting problem in the case of Jeff than those who received the case order of Jeff-Sophie-Bill (low to high). By the same token, of those participants who received the case order of Bill-Sophie-Jeff (high to low) a significantly smaller

proportion identified “Neither CSA nor SA” as the primary presenting problem in the case of Jeff than those who received the case order of Jeff-Sophie-Bill (low to high). Simply put, those participants who were exposed to the case of Jeff first were significantly less likely to identify Jeff as having either CSA or SA than when they were exposed to it last.

Furthermore, while case order did not appear to make a significant difference on participants’ tendency to perceive CSA symptoms in response to the cases of both Jeff and Sophie, it did seem to make a significant difference in their responses to the case of Bill. Those participants who received the case order of Jeff-Sophie-Bill (low to high) showed a tendency to perceive significantly more CSA symptoms in the case of Bill than those who received the case order of Bill-Sophie-Jeff (high to low). Put another way, those participants who were exposed to the case of Bill first indicated that they thought he had significantly less CSA symptoms than when they were exposed it last.

Effects of survey completion method on Question 1 and Question 2 of the dependent measure (CVSI-V3). An examination of the effects of survey completion method (online vs. mail) on participants identification of CSA (or “Either CSA or SA”) as the primary presenting problem (Question 1 of the CVSI-V3) and on their tendency to perceive CSA symptoms (Question 2 of the CVSI-V3) yielded mixed findings. While survey completion method used did not appear to significantly influence whether participants identified the primary presenting problem as “CSA only” or “Either CSA or SA” in response to the cases of both Jeff and Sophie, it did seem to make a significant difference in their

responses to the case of Bill. Of those participants who completed the surveys online a significantly larger proportion identified "Either CSA or SA" as the primary presenting problem in the case of Bill than those who completed the surveys on paper by mail. By the same token, of those participants who completed the surveys by mail, a significantly smaller proportion identified "Neither CSA nor SA" as the primary presenting problem in the case of Bill than those who completed the surveys online. Simply put, those participants who completed the surveys online were significantly more likely to identify Bill as having either CSA or SA than when they completed the surveys by mail.

An examination of the effects of survey completion method (online vs. mail) on participants' tendency to perceive CSA symptoms (Question 2 of the CVSI-V3) also yielded mixed findings. While whether a participant completed the surveys online or on paper via mail appeared to make no difference in participants' perception of CSA symptoms in the cases of both Sophie and Bill. However, for the case of Jeff, participants who completed the surveys by mail showed a tendency to perceive significantly more CSA symptoms than those who completed the surveys online.

Implications of Findings for Practitioners

The implications of the findings from this study for practitioners (i.e., other mental health professionals) are several. First, the findings from this study bring to the fore questions about how expertise in sex/cybersex addiction (or in any field for that matter) is currently defined. As previously indicated, training is a broad term, encapsulating everything from attending workshops and seminars,

to reviewing literature, to supervised practice, to repeated exposure to clients with said issue in a regular and predictable environment over time followed by prompt feedback. Practitioners seeing clients with cybersex-related problems are encouraged to engage with the question of whether taking courses or reading material, in the absence of supervised practice, frequent client exposure and feedback (i.e., deliberate practice), is sufficient to build, attain and maintain expertise in sex/cybersex addiction. As mental health practitioners, and with a growing demand for clinicians who can provide effective treatment of sex/cybersex-related compulsive behaviour, it behooves us to distinguish and augment those activities considered necessary, but not sufficient in-and-of themselves, to build and hold expertise in this field.

Second, this research has highlighted the importance of building in checks and balances to catch judgement heuristics that may be influencing clinical judgement without conscious awareness. Especially with regards to online sex-related presenting concerns among clients, supervised practice and consultation with true experts in the field of sex/cybersex addiction is not only warranted but recommended as a means of reducing possible biases that could be influencing clinical judgement.

Third, the findings from this study suggest that practitioners who do not hold expertise in Internet-related sexual problems should think very hard about taking on or continuing to treat clients with this issue. As we have seen in this study, the absence of expertise may be an important piece of why psychologists in this study were unable to accurately identify and perceive cybersex addiction as

the presenting problem where appropriate. Again, given the increasing prevalence of cybersex-related problems, practitioners without the necessary expertise in sex/cybersex addiction may do well to have and make use of a strong referral network of clinicians who are experts in the field.

Finally, if referral of a client with online sexual problems is not an option or a preference, and expertise in sex/cybersex addiction has not yet been attained, practitioners are encouraged to seriously consider putting in place protocols for use with such clients that invoke System 2 thinking. Findings from this study suggest that participants varied tremendously in whether they identified cybersex addiction as the primary presenting problem in need of therapeutic attention and their subsequent ability to perceive cybersex addiction symptom criteria.

Limitations of this Study

The argument of what sexual content is legal versus illegal and whether to attempt to regulate Internet sex content is a complicated and ongoing one in courts around the world (Mehta, 2002; Young, 2000; McGregor, n.d.; Sekulow & Henderson, 1996; Shapiro, 2005; Brown, 2006) and is beyond the scope of this study. In Canada, cybersex that depicts children under the age of 18 engaged in sexual acts and "snuff" porn, in which people die, are considered illegal to watch or own (Options for Sexual Health, 2012). Showing children pornography or cybersex, or engaging in online sexual chat with a person considered a minor *in their country* are also considered illegal in Canada (Options for Sexual Health, 2008). While one of the cybersex activities that people engage in is the viewing of illegal material, this study did not examine the implications of this on

therapists' evaluations of the presenting problems of clients in Canada. In part, this is due to the constantly shifting nature of legal standards regarding sexual content on the Internet. Primarily, however, this is due to the fact that certain illegal activities, such as viewing child pornography, snuff films, or attempting to lure a child online for sex are emotionally loaded topics. It is likely that, were this element of behaviour to have been included among cybersex addicted clients presenting for therapy, then therapists' sexual attitudes would have been influenced by other values, such as morality. It is also likely that if a cybersex addicted individual was to present to therapy indicating an attraction to child-related sexual content, the therapist would immediately diagnose the client's behaviour (rightly or wrongly) as Pedophilic Disorder (APA, 2013), leaving little room for the examination of other differential diagnoses to surface as potential alternatives.

Another area that was not examined in this study is that of the effects of youth or children presenting to therapy with cybersex addiction. As the prevalence of the Internet grows, the age of techno-aficionados decreases. It is not unusual to find children as young as 5-years of age with the ability to navigate the Internet these days. Despite this, researchers in the field of cybersex addiction are only starting to examine the effects of cybersex on youth and the implications on their long term development. Children or teenagers presenting for therapy also bring with them other issues that may involve therapist's values, such as potentially distorted views of childhood innocence and/or beliefs about what subjects should or should not be discussed with children. Due to both the novelty

of this area of research and the above noted potential attitudes of therapists about childhood, the inclusion in this study of youth cybersex addiction would only have muddied the waters. As a result the focus was kept on adults with cybersex addiction.

Other variables not included in this study are the role of the client's age, gender, sexual orientation and/or marital status in the therapist's perception of the presence of cybersex addiction. The various ways in which cybersex addiction manifests among clients as either online only, online leading to real-time sexual encounters, or some variation thereof, were also not examined. Cybersex addicts have available to them and can compulsively use dating sites, message boards, erotic chat, live web cams, still images, streaming video, mobile phone apps, Facebook, chat roulette, and instant messaging (IM), etc., as both ends unto themselves as well as means that have led to real-time sexual encounters with others (Weiss & Samenow, 2010; Lazar, 2010 as cited in Weiss & Samenow, 2010; Bosker, 2010; Smith, 2010; Schneider & Weiss, 2001; Weiss & Schneider, 2006; Carnes, Delmonico, Griffin, & Moriarty, 2001; Young, 2001; Yassa, 2006; Yassa, 2008). While these variables are of interest, their addition to this study would have resulted in a more complex design, added vignettes for respondents to review and answer questions about, and a larger sample size requirement. Design complexity, length and sample size would also have been increased with the inclusion of the variables of therapist's sexual orientation, marital status, and religion. More vignettes and/or question items to be completed would have increased survey completion time, which may then have increased the rate of

respondent refusal to participate or drop-out rate. In light of this, the sample size would then have proven difficult to achieve. These variables, along with other potentially interesting variables like client and therapist shame, previous addiction history, abuse history, and presence of therapist's cybersex addiction pose an opportunity for future researchers to expand upon.

Furthermore, as indicated throughout this paper, clients with cybersex addiction can present to therapy without disclosing any of their cybersex activities and problems. This lack of disclosure may be due either to a lack of insight that the behaviour is in any way related to the client's overall problems or due to intentional deception. Intentional deception is often motivated by denial, shame, embarrassment, mistrust of the therapist, or the client's perception of the therapist as potentially judging them or having a negative sexual attitude. As indicated earlier, there is also a small subgroup of clients who present to therapy as a result of their cybersex-related problems, disclose their online sexual activities to their therapist, but as yet have no insight into the connection between their online sexual activities and the problems in their lives. Furthermore, as the literature suggests, even when presented with the details of clients' online sexual acting out, therapists frequently minimize or dismiss the behaviour as the source of clients' overall problems. This study was limited to therapists' perceptions of the presenting problem of clients who reveal their online sexual acting out in therapy but may not have insight into or disclose the role of this behaviour in their overall problems. This is necessary as methodologically it is not possible to determine a therapist's ability to identify cybersex addiction among clients in the absence of

any information regarding the online sexual acting out.

Finally, it is important to recognize the limitations of research that relies on self-report surveys, especially with sensitive material (such as sexual attitudes) and study requirements for participation. It remains possible that in spite of specific steps taken to ensure not only anonymity, but also all appearances of anonymity, participants may have still been uncomfortable providing responses to questions about their sexual preferences, leading them to possibly provide deceptive responses instead. By the same token, anonymity meant that participants' claims of meeting study requirements for participation could not be verified, making it possible that respondents could have lied about either their registration status and/or whether they were currently practicing. Both possibilities are an area of vulnerability in this study's design, but could not have been handled differently while still maintaining participant anonymity given the time and financial constraints of this research. Nonetheless, it is a vulnerability of this study that should be taken into consideration.

Delimiters of this Study

This study included currently practicing psychologists who were specifically registered with their provincial regulatory body in Canada *and* were either members of the provincial voluntary associations called the Psychologists' Association of Alberta (PAA) and/or of the national voluntary association called the Canadian Psychological Association (CPA). The reasons for limiting the scope of participants to these individuals were two-fold. First, the College of Alberta Psychologists (CAP) did not agree to participate in this study and their

representatives indicated, when contacted, that they do not get involved in research initiatives. Given the time investment involved in appealing to each independent provincial regulatory body and the possibility that their response may be similar to that of CAP, it was determined that going through voluntary membership associations would still provide access to the sample desired and would be faster. Second, registered psychologists, as compared to un-registered mental health workers, are permitted to communicate a diagnosis to their clients (a regulated act). This permission to communicate a diagnosis means that registered psychologists were likely to have greater familiarity with the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) than other unregulated mental health workers. The subsequent result of limiting the scope of this study to currently practicing psychologists registered in Canada with their provincial regulatory body is two-fold: (a) findings can only be generalized to other registered psychologists, and (b) findings may have limited generalizability outside of Canada, since both Master's and doctoral level practitioners are permitted to register as psychologists in some (although not all) provinces of Canada but this is not necessarily the case for those registered to practice psychology outside of Canada.

Furthermore, direct generalization of the findings of this study to therapists' work with real cybersex addicted clients may not be possible. Due to financial and time restrictions, written fictional case vignettes (as opposed to real clients or video-taped clients) were created to communicate the symptoms of a client with cybersex addiction presenting for therapy. While the benefit is a more

replicable study, the disadvantages are that the written fictional client vignettes may not have been as valid a representation of a cybersex addicted client coming for therapy as a real-life or even video-taped client might have been. Written vignettes are, of course, missing visual and auditory cues that most therapists rely on, in addition to accurate history taking and assessment, to make their diagnosis. Results of this study, therefore, may give us only an indication of how therapists might respond to cybersex addicted clients when they are presented with them in real-life therapy.

Conclusion and Recommendations for Future Researchers

Mental health clinicians are dealing with a rapidly growing prevalence of clients presenting with cybersex addiction (Freeman-Longo, 2000; Young, 2001). Due to a tendency on the part of such clients to avoid disclosure or remain unaware of the problems caused by their relationship to cybersex, mental health clinicians must be more skilled at identifying when the primary issue in need of therapeutic attention is indeed cybersex addiction (Delmonico, 2002). This exploratory study was designed to ascertain whether psychologists can indeed identify when the presenting problem is cybersex addiction among non-disclosing clients. Research questions were framed that examined whether differences existed in the proportions with which participants identified cybersex addiction as the primary presenting concern, as well as whether psychologists' personal or professional characteristics played any role in their tendency to perceive cybersex addiction as the presenting problem.

A measure called the CVSI that involved three fictional client case vignettes was created for the purposes of answering the research questions, and it was piloted in Phase I of the study on a sample of 10 Doctoral-level graduate students in psychology and three Expert Validators to determine its construct and internal validity. Each case vignette contained a different number of built-in cybersex symptom criteria, resulting in two that met criteria for diagnostic endorsement and one that did not. The three client case vignettes used in this study were not designed to be directly comparable to each other due to variations in client characteristics. Piloting resulted in three versions of the CVSI and the third version was used for Phase II of this study. Once the pilot was complete, fully registered and currently practicing psychologists were recruited in Phase II via one national and one provincial voluntary membership association by mail and online, culminating in a sample of 93 participants. Participants completed the CVSI-V3, the SOS-R-M, and a demographic survey.

Because of the exploratory nature of this study, alpha was set at .10. Results of this study showed that a significant proportion of psychologists missed correctly identifying CSA as the primary presenting problem among the clients who had it, but correctly avoided identifying CSA as the primary presenting problem among the client who didn't have it. The combination of psychologists' age, number of years in practice, Internet familiarity, sexual attitude, and amount of training in sex/cybersex addiction did not prove a significant predictor of those same psychologists' perceptions of cybersex addiction as the presenting problem among clients that did and did not have the disorder. Neither psychologists' age,

sexual attitude, gender, nor province of registration had a significant effect on their perceptions of CSA symptoms among clients who either did or did not have cybersex addiction. Doctoral-level psychologists displayed significantly more conservatism in their perception of cybersex addiction as the presenting problem than did Master's-level psychologists, resulting in greater accuracy. All psychologists in this study, however, consistently over-perceived cybersex addiction as the presenting problem among both clients with and without the disorder.

The theoretical framework selected to help explain the findings was based predominantly on the works of Kahneman (2011) and Ericsson (2006) and involved the interplay between expertise and judgement heuristics, and the tendency for the latter to increase in the absence of the former. This was postulated to explain the complex and mixed findings in which participants seemed unable to identify (i.e., label) cybersex addiction among the clients in the vignettes that endorsed the illness, but displayed a tendency to perceive cybersex addiction as the presenting problem (via symptom recognition) among the same. The literature on expertise also suggested a minimized role of individual personal characteristics in the development of true expertise. This was postulated to explain the findings in which all personal and professional clinician characteristics measured were found to not influence participant perceptions of cybersex addiction as the presenting problem, with the exception only of highest level of education.

Several limitations of this study were identified. These included the avoidance of including specifically illegal and/or paraphilic online sexual content or behaviour. Also, variables in the case vignettes such as client age, gender, sexual orientation, marital status, type of sexual acting out behaviour, virtual or real sexual activity, number of partners, and type of platforms used for online sexual behaviour were not included in the design, measurement, and analysis of this study. Additionally, therapist variables such as sexual orientation, marital status, religion, shame, and previous abuse or addiction history were not included in the design, measurement, and analysis of this study, either alone or in interaction with the client variables indicated above. This is unfortunate as discussion of the results of this study suggest that, in hindsight, inclusion of client variables may have helped explain some of the variation seen in the findings, in particular had they been studied in interaction with therapist variables.

Some areas for further research include the further examination of the role of expertise in the identification of cybersex addiction, in particular whether it would predict the accuracy of clinical judgements of those who are certified as experts in the field and differentiate them reliably from non-experts. More research on judgement heuristics would help clarify its impact on the differential diagnosis of cybersex addiction and whether its use differs between experts and non-experts in the field. Whether there is any interaction between the personal characteristics of clinicians and those of the clients could also help more clearly identify when judgement heuristics are being used and alert those clinicians who might be at greater risk of using them. Further examination of what helps

mitigate the use of judgement heuristics in dealing with clients with sexual and online sexual problems would serve both clients and clinicians alike. Finally, further examination into the role of education level on developing expertise as a specialist in cybersex addiction is needed.

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Appendices

Appendix A

Overview of Study Method (Phases I and II)

Overview of Study Method (Phases I and II)

Phase	Participants	Survey Order	CVSI Case Order	Step	Actions
Pilot	PhD Clinical or Counselling Psychology Students & Experts in the field of Sex or Cybersex Addiction	1. Demographic 2. SOS-R-M 3. CVSI-V1	<u>CVSI-V1*</u> 1. Sophie 2. Bill 3. Jeff	1	Surveys link sent out to CPA student section members online via listserv & e-Newsletter
					Surveys link sent out to University of Alberta PhD Students online via graduate listserv, in-class recruitment, followed by email distribution by professors
					surveys link sent out to University of Calgary PhD Students online via graduate listserv and email distribution by professors
		Expert Validators received CVSI only			survey CVSI v1 sent out Expert Validators #1 & 2
				2	Data collected and analysed from all pilot participants and Expert Validators above
				3	Edits made to CVSI v1
			<u>CVSI-V2‡</u> 1. Jeff 2. Sophie 3. Bill	4	survey CVSI v2 sent out to Expert Validator #3
				5	Data collected and analysed from Expert Validator #3
				6	Edits made to CVSI v2
Main Study	Currently Practicing Registered Psychologists	1. CVSI-V3 2. SOS-R-M 3. Demographic	<u>CVSI-V3⁺</u> 1. Jeff 2. Sophie 3. Bill AND 1. Bill 2. Sophie 3. Jeff	1	surveys sent out PAA members via mail and online via website ad
					surveys sent out to CPA members of 12 different sections online and via CPA research portal
				2	Data collected and analysed from main study participants

Note:

*CVSI-V1 = Client Vignette Scoring Instrument Version 1; CVSI-V2 = Client Vignette Scoring Instrument Version 2; CVSI-V3 = Client Vignette Scoring Instrument Version 3; SOS-R-M = Modified Sexual Opinion Survey Revised; Demographic = Demographic Survey; *CVSI-V1: Jeff = 2 CSA symptoms built in (no diagnosis), Sophie = 4 CSA symptoms built in (meets diagnosis), Bill = 9 symptoms built in (maximum for diagnosis); ‡CVSI-V2: Jeff = 2 CSA symptoms built in (no diagnosis), Sophie = 4 CSA symptoms built in (meets diagnosis), Bill = 9 symptoms built in (maximum for diagnosis); ⁺CVSI-V3: Jeff = 1 CSA symptom built in (no diagnosis), Sophie = 3 CSA symptoms built in (minimum for diagnosis), Bill = 9 CSA symptoms built in (maximum for diagnosis)*

Appendix B

Addictive Disorder Diagnostic Criteria

Addictive Disorder

(Goodman, 2001)

A maladaptive pattern of behaviour, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period,

1) Tolerance, as defined by either of the following:

> a) a need for markedly increased amount or intensity of the behaviour to achieve the desired effect;
>
> b) markedly diminished effect with continued involvement in the behaviour at the same level of intensity,

2) Withdrawal, as manifested by either of the following:

> a) characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the behaviour,
>
> b) the same (or a closely related) behaviour is engaged in to relieve or avoid withdrawal symptoms,

3) The behaviour is often engaged in over a longer period, in greater quantity or at a higher level of intensity than was intended.

4) There is a persistent desire or unsuccessful efforts to cut down or control the behaviour.

5) A great deal of time is spent in activities necessary to prepare for the behaviour, to engage in the behaviour or to recover from its effects.

6) Important social, occupational or recreational activities are given up or reduced because of the behaviour.

7) The behaviour continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the behaviour.

Appendix C

Sex Addiction (SA) Diagnostic Criteria

Sex Addiction (SA)

(Goodman, 1998c)

A maladaptive pattern of sexual behaviour, leading to clinically significant impairment or distress, as manifested by three (or more) of the following and occurring at any time in the same 12-month period,

1) Tolerance, as defined by either of the following:

> a) a need for markedly increased amount or intensity of the sexual behaviour to achieve the desired effect;
>
> b) markedly diminished effect with continued involvement in the sexual behaviour at the same level of intensity,

2) Withdrawal, as manifested by either of the following:

> a) characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the sexual behaviour,
>
> b) the same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms,

3) The sexual behaviour is often engaged in over a longer period, in greater quantity or at a higher level of intensity than was intended.

4) There is a persistent desire or unsuccessful efforts to cut down or control the sexual behaviour.

5) A great deal of time is spent in activities necessary to prepare for the sexual behaviour, to engage in the behaviour or to recover from its effects.

6) Important social, occupational or recreational activities are given up or reduced because of the sexual behaviour.

7) The psychological problem that is likely to have been caused or exacerbated by the sexual behaviour continues despite knowledge of its consequences.

Appendix D

Cybersex Addiction (CSA) Diagnostic Criteria

Cybersex Addiction (CSA)

(Adapted with permission from Goodman, 1998c)

A maladaptive pattern of online sexual behaviour, leading to clinically significant impairment or distress, as manifested by three (or more) of the following and occurring at any time in the same 12-month period,

1) Tolerance, as defined by either of the following:

> a) a need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect;
>
> b) markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity,

2) Withdrawal, as manifested by either of the following:

> a) characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour,
>
> b) the same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms,

3) The online sexual behaviour is often engaged in over a longer period, in greater quantity or at a higher level of intensity than was intended.

4) There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour.

5) A great deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour or to recover from its effects.

6) Important social, occupational or recreational activities are given up or reduced because of the online sexual behaviour.

7) The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences.

Appendix E

Obsessive-Compulsive Disorder (OCD) Diagnostic Criteria

Obsessive Compulsive Disorder (OCD)

(APA, 2000, p. 462)

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note**: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Appendix F

Hypersexual Disorder (HD) Diagnostic Criteria

Proposed Hypersexual Disorder Diagnostic Criteria

(APA, 2010)

A. Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:

(1) Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior.
(2) Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
(3) Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events.
(4) Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior.
(5) Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others.

B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.

C. These sexual fantasies, urges, and behavior are not due to direct physiological effects of exogenous substances (e.g., drugs of abuse or medications) or to Manic Episodes.

D. The person is at least 18 years of age.

Specify if: [22]
Masturbation
Pornography
Sexual Behavior With Consenting Adults
Cybersex
Telephone Sex
Strip Clubs
Other:

Specify if:
In Remission (No Distress, Impairment, or Recurring Behavior and in an Uncontrolled Environment): State duration of remission in months:____
In a Controlled Environment

Appendix G

Online Version of Client Vignette Scoring Instrument - Version 1 (CVSI-V1) (Phase I)

Questionnaire #3

Dear Participant:
Below are 3 fictional client cases. After each case there are 2 sets of questions.
Please read through each case carefully in turn and answer the questions immediately following it.
Thank you.

CASE 1 - SOPHIE.

Sophie tells you she has come to see you because she has lost her job recently and is experiencing intense anger about this and is having difficulty letting it go and moving on to search for other work. Her executive recruiter told her to get some help with her anger.

A single executive in her mid-30s, Sophie would say with a smile that her Achilles' heel was her "weakness for good-looking men". When an attractive man indicated to Sophie that he was interested in her sexually, she found herself unable to resist, or more accurately, she found herself unable to want to resist. She experienced herself almost as a victim, sexually drawn to men against her will. It felt similar to when her swim coach used to flirt with her when she was 13. He ultimately ended up sexually abusing Sophie repeatedly.

When Sophie discovered online chat groups she suddenly had access to all sorts of men online who seemed to be interested in being sexual with her. Her friends said it was the only time they saw her show any interest in anything these days given how bored she had been saying she was with everything in her life. She began emailing back and forth with several men whom she had never met before but had encountered on the Internet chat groups. It escalated.

Over a few weeks she began spending 4-5 hours during the workday checking and responding to her email. Soon she and various men online began to instant message (IM) each other. In this way they became constantly available to each other online throughout the workday. She went to her office earlier and stayed at work later so she could stay online later. Then it became weekends too. In some ways she felt she had to be tapped into what was happening online in these chat groups at all times, otherwise she felt upset and anxious. She started losing lots of weight very quickly, but she reasoned it was because she had been working so hard. She barely slept, staying up all night composing emails in her head or fantasizing about what might happen if she met any of the online men in person.

When some of the men she was communicating with online started asking to meet with her, Sophie, again, found herself unable to say "no". She began meeting with the men over her lunch hour. Meetings in coffee shops became meetings in her apartment and rapidly progressed from flirtations to sex. At first Sophie felt guilty about having sex with men she hardly knew at all but she brushed these feelings aside telling herself she was a modern woman. Sophie's fiancé ended their engagement after she repeatedly broke promises to him that she would stop sleeping with other men. After the breakup Sophie felt worthless and terribly guilty for months, but this did not stop her from continuing to meet with the men from online.

When Sophie began to use her apartment in the city for midday sexual liaisons, her lunch breaks stretched longer and longer. Her formerly superior work performance began to slacken and she did not receive an expected promotion. At work, Sophie had a hard time thinking or concentrating on the tasks in front of her. Sophie's boss warned her that she could lose her job if she was unable to keep business and personal separate in her life. Sophie resolved that she would turn over a new leaf and for six weeks she kept her sexual behaviour in check, disconnected her internet access at work and stopped visiting the online chat groups.

Then, when she was working late one night and had just finished a big project, she noticed that her neck and back were tight, and told herself she would just unwind a little with a quick visit to the online chat group. As she logged in, in the back of her mind, a tiny thought that her need to go online felt too strong was quickly quieted. Within minutes she was instant messaged by one of the men online for a sexual rendezvous. Since there was no one at the office at this late hour, Sophie justified that it would be alright. When a male co-worker walked in on her sexual activities, Sophie knew there might be repercussions, yet she continued to liase with men from the online chat group during her lunch hours. At the same time the co-worker who had walked in on Sophie began to pressure her for sexual favours. When she brushed him off, he disclosed to the boss Sophie's after hours office activities. Since this was against company policy, she was fired immediately.

CASE 1 – QUESTION 1.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Sophie).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

2. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

3. Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

9. Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

10. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

11. Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

12. Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind (not imposed from without as in thought insertion)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

13. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

14. Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

15. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

16. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

17. Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

18. Driven and repetitive behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive, but are nevertheless aimed at preventing or reducing distress or preventing some dreaded event or situation

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

19. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

20. Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

21. Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

22. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

23. Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

24. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

25. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

26. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

27. Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

CASE 1 – QUESTION 2.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Sophie).

A ranking of '1' means that you believe this to be THE PRIMARY PROBLEM in need of therapeutic attention, while a ranking of '5' means that you believe this to be THE MOST PERIPHERAL PROBLEM in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

	Ranking
Delirium, dementia, or other cognitive disorder	
Substance-Induced Mood Disorder (manic features)	
Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)	
Major Depressive Disorder – Single Episode	
Major Depressive Disorder – Recurrent	
Dysthymic Disorder	
Depressive Disorder NOS	
Bipolar I Disorder	
Bipolar II Disorder	
Cyclothymic Disorder	
Obsessive-Compulsive Disorder	
Posttraumatic Stress Disorder	
Hypoactive Sexual Desire Disorder	
Dissociative Disorder	
Delusional Disorder (erotomania)	
Paraphilia	
Paraphilia NOS	
Sex Addiction	
Cybersex Addiction	
Gender Identity Disorder in Adults	

Sexual Disorder NOS	
Impulse-Control Disorder NOS	
Adjustment Disorder (disturbance of conduct)	
Borderline Personality Disorder	
Avoidant Personality Disorder	
Relational Problems	
Religious or Spiritual Problem	
Phase of Life Problem	
Unspecified Mental Disorder (nonpsychotic)	

CASE 2 – BILL.

Bill tells you he has come to see you because he was has lost his marriage and is feeling depressed and suicidal. His pastor suggested Bill get some support coping with the loss of his marriage and referred Bill to you.

An electrician in his mid-20s, married for 3 years, Bill had masturbated nearly every night before going to sleep since his middle teens when he first discovered online porn pictures and videos. When he quit using alcohol and other drugs in his early 20s, his sexual fantasies and urges became more frequent and more intense. At about the same time his wife and his sister started commenting that Bill appeared to be depressed, moping about the house when home and not seeing his friends anymore.

He began to experience strong urges to masturbate in the morning, usually after having had a hard time getting to sleep, which was a frequent occurance. He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife. During these times, his wife and coworkers would notice and tell Bill to relax and that he was making them nervous because he was so jumpy. Consequently, he started to view online porn and masturbate before work, even though he would sometimes arrive late, dazed and zoned out as a result.

Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours. Bill would search for hours for sexual images, sorting them into meticulous categories and folders and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his private locker at work. When Bill would find the "perfect" image he would stop searching and masturbate to it.

No longer sufficiently excited by viewing porn online, Bill began to purchase online "live" strippers and "live" streaming videos of sexual acts. He wife caught him at home one day and told him if he didn't stop she would leave him, and he received a second warning about tardiness and inattentiveness at work. He felt disgusted with himself and started to have recurring thoughts of killing himself and escaping all the problems; but each time he tried to stop going online to surf for sex, he would fail.

Sexual images and fantasies accompanied by arousal would intrude into his consciousness throughout the day, whether he wanted them to or not, and he would feel as though he was going to explode. At night Bill was having difficulty sleeping, feeling jittery and unable to relax with sexual images swirling through his head. The only thing that would make them go away was logging back online to search for and look at more sex sites. He occasionally thought to himself that this was crazy and that he was stuck in a never-ending loop.

When his wife became pregnant, he deleted his collection of online pornography and his list of online favorites and resolved to quit masturbating. Within a few months, though, he again lost control of his online surfing and masturbation and the marriage soon fell apart. Before long he had "maxed-out" his credit cards. Socially isolated, deeply in debt, suicidal, and about to lose his job, Bill felt powerless.

CASE 2 – QUESTION 1.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Bill).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

2. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

3. Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

9. Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

10. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

11. Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

12. Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind (not imposed from without as in thought insertion)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

13. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

14. Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

15. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

16. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

17. Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

18. Driven and repetitive behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

19. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

20. Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

21. Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

22. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

23. Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

24. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

25. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

26. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

27. Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

CASE 2 – QUESTION 2.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Bill).

A ranking of '1' means that you believe this to be THE PRIMARY PROBLEM in need of therapeutic attention, while a ranking of '5' means that you believe this to be THE MOST PERIPHERAL PROBLEM in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

	Ranking
Delirium, dementia, or other cognitive disorder	
Substance-Induced Mood Disorder (manic features)	
Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)	
Major Depressive Disorder – Single Episode	
Major Depressive Disorder – Recurrent	
Dysthymic Disorder	
Depressive Disorder NOS	
Bipolar I Disorder	
Bipolar II Disorder	
Cyclothymic Disorder	
Obsessive-Compulsive Disorder	
Posttraumatic Stress Disorder	
Hypoactive Sexual Desire Disorder	
Dissociative Disorder	
Delusional Disorder (erotomania)	
Paraphilia	
Paraphilia NOS	
Sex Addiction	
Cybersex Addiction	
Gender Identity Disorder in Adults	

Sexual Disorder NOS	
Impulse-Control Disorder NOS	
Adjustment Disorder (disturbance of conduct)	
Borderline Personality Disorder	
Avoidant Personality Disorder	
Relational Problems	
Religious or Spiritual Problem	
Phase of Life Problem	
Unspecified Mental Disorder (nonpsychotic)	

CASE 3 – JEFF.

Jeff tells you he has come to see you because he is feeling very anxious about the hospital Chief of Staff's recommendation that he take some time off work and is worried about his career.

Jeff, a married neurologist in his 40s, feels tired and without energy all the time now. It doesn't seem to matter how much time he sets aside for sleep, he just never sleeps more than 2-3 hours a night. This has been going on for 2 months.

In his marriage, sex was among one of the main sources of tension. Jeff wanted to have sex with his wife every day, sometimes two or three times a day. He thought about having sex almost constantly, accompanied by feelings of intense nervousness that his wife would turn him down again if he asked. He knew his mind had worked this way since he was a young man. When she declined to have sex with Jeff, he felt desperate and feared that she did not love him, that he was not good enough for her, that she was tired of him and was preparing to leave him.

On such occasions, and sometimes to interrupt the almost constant thoughts of sex, he withdrew to his study and immersed himself in work, rechecking patient diagnoses. Sometimes for a few hours a night several times a week he would attempt to get his sexual needs met by reading online erotica and masturbating, but he did not seek sex elsewhere. Sometimes he felt guilty about looking online for sexual release but he didn't know what else to do.

When Jeff wasn't working and thinking about sex he was eating. In fact, he and his wife and colleagues had noticed that he had gained 10-15 lbs in the last month alone. When his wife's inflammatory bowel disease flared up, Jeff cared for her sensitively, and she expressed her appreciation and gratitude. At such times, Jeff felt needed and valued and rarely thought of sex. Jeff's desire for sex occasionally offended his wife, who felt then that he would rather have sex than talk with her. Sometimes when Jeff's wife complied with his requests for sex, she resented him.

Several of Jeff's colleagues had commented to him in the last couple of weeks that he didn't look his usual brisk self, and that he looked slowed down and depressed. The Chief of Staff had called Jeff into his office and indicated that perhaps Jeff should seek counselling from the hospital EAP, and maybe take some time off work after completing his backlog of incomplete patient charts.

CASE 3 – QUESTION 1.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Jeff).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

2. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

3. Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

9. Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

10. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

11. Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

12. Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind (not imposed from without as in thought insertion)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

13. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

14. Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

15. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

16. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

17. Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

18. Driven and repetitive behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

19. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

20. Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

21. Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

22. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

23. Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

24. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

25. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

26. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

27. Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning)

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

CASE 3 – QUESTION 2.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Jeff).

A ranking of '1' means that you believe this to be THE PRIMARY PROBLEM in need of therapeutic attention, while a ranking of '5' means that you believe this to be THE MOST PERIPHERAL PROBLEM in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

	Ranking
Delirium, dementia, or other cognitive disorder	
Substance-Induced Mood Disorder (manic features)	
Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)	
Major Depressive Disorder – Single Episode	
Major Depressive Disorder – Recurrent	
Dysthymic Disorder	
Depressive Disorder NOS	
Bipolar I Disorder	
Bipolar II Disorder	
Cyclothymic Disorder	
Obsessive-Compulsive Disorder	
Posttraumatic Stress Disorder	
Hypoactive Sexual Desire Disorder	
Dissociative Disorder	
Delusional Disorder (erotomania)	
Paraphilia	
Paraphilia NOS	
Sex Addiction	
Cybersex Addiction	
Gender Identity Disorder in Adults	

Sexual Disorder NOS	
Impulse-Control Disorder NOS	
Adjustment Disorder (disturbance of conduct)	
Borderline Personality Disorder	
Avoidant Personality Disorder	
Relational Problems	
Religious or Spiritual Problem	
Phase of Life Problem	
Unspecified Mental Disorder (nonpsychotic)	

Appendix H

CVSI-V1 and CSA, MDD & OCD Subscale Scoring Protocols

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 1 – Sophie.

Sophie tells you she has come to see you because she has lost her job recently and is experiencing intense anger about this and is having difficulty letting it go and moving on to search for other work. Her executive recruiter told her to get some help with her anger.

A single executive in her mid-30s, Sophie would say with a smile that her Achilles' heel was her "weakness for good-looking men". When an attractive man indicated to Sophie that he was interested in her sexually, she found herself unable to resist, or more accurately, she found herself unable to want to resist. She experienced herself almost as a victim, sexually drawn to men against her will. It felt similar to when her swim coach used to flirt with her when she was 13. He ultimately ended up sexually abusing Sophie repeatedly.

When Sophie discovered online chat groups she suddenly had access to all sorts of men online who seemed to be interested in being sexual with her. Her friends said it was the only time they saw her show any interest in anything these days given how bored she had been saying she was with everything in her life. She began emailing back and forth with several men whom she had never met before but had encountered on the Internet chat groups. It escalated.

Over a few weeks she began spending 4-5 hours during the workday checking and responding to her email. Soon she and various men online began to instant message (IM) each other. In this way they became constantly available to each other online throughout the workday. She went to her office earlier and stayed at work later so she could stay online later. Then it became weekends too. In some ways she felt she had to be tapped into what was happening online in these chat groups at all times, otherwise she felt upset and anxious. She started losing lots of weight very quickly, but she reasoned it was because she had been working so hard. She barely slept, staying up all night composing emails in her head or fantasizing about what might happen if she met any of the online men in person.

When some of the men she was communicating with online started asking to meet with her, Sophie, again, found herself unable to say "no". She began meeting with the men over her lunch hour. Meetings in coffee shops became meetings in her apartment and rapidly progressed from flirtations to sex. At first Sophie felt guilty about having sex with men she hardly knew at all but she brushed these feelings aside telling herself she was a modern woman. Sophie's fiancé ended their engagement after she repeatedly broke promises to him that she would stop sleeping with other men. After the breakup Sophie felt worthless and terribly guilty for months, but this did not stop her from continuing to meet with the men from online.

When Sophie began to use her apartment in the city for midday sexual liaisons, her lunch breaks stretched longer and longer. Her formerly superior work performance began to slacken and she did not receive an expected promotion. At work, Sophie had a hard time thinking or concentrating on the tasks in front of her. Sophie's boss warned her that she could lose her job if she was unable to keep business and personal separate in her life. Sophie resolved that she would turn over a new leaf and for six weeks she kept her sexual behaviour in check, disconnected her internet access at work and stopped visiting the online chat groups.

Then, when she was working late one night and had just finished a big project, she noticed that her neck and back were tight, and told herself she would just unwind a little with a quick visit to the online chat group. As she logged in, in the back of her mind, a tiny thought that her need to go online felt too strong was quickly quieted. Within minutes she was instant messaged by one of the men online for a sexual rendezvous. Since there was no one at the office at this late hour, Sophie justified that it would be alright. When a male co-worker walked in on her sexual activities, Sophie knew their might be repercussions, yet she continued to liase with men from the online chat group during her lunch hours. At the same time the co-worker who had walked in on Sophie began to pressure her for sexual favours. When she brushed him off, he disclosed to the boss Sophie's after hours office activities. Since this was against company policy, she was fired immediately.

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 1 – Question 1.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Sophie).

A rating of '0' indicates that you believe the problem described to be ***Not at all contributing*** in the case above, while a rating of '4' indicates that you believe it to be ***A key contributor***.

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

0 1 2 3 4

2. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

3. Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

0 1 2 3 4

4. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

0 1 2 3 4

5. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

6. The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems

0 1 2 3 4

7. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

0 1 2 3 4

8. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

9. Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action

0 1 2 3 4

10. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

11. Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

12. Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind (not imposed from without as in thought insertion)

0 1 2 3 4

13. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

0 1 2 3 4

14. Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

15. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly

0 1 2 3 4

16. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

0 1 2 3 4

17. Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

18. Driven and repetitive behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connect in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

0 1 2 3 4

19. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

0 1 2 3 4

20. Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

21. Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

22. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

0 1 2 3 4

23. Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

24. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships

0 1 2 3 4

25. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

0 1 2 3 4

26. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

27. Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 1 – Question 2.

Instructions: From the list below, please select and rank the top 5 presenting problems you believe to be illustrated in preceding case (Sophie).

A ranking of '1' means that you believe this to be the ***primary problem*** in need of therapeutic attention, while a ranking of '5' means that you believe this to be the ***most peripheral problem*** in need of the therapeutic attention.

- ☐ Delirium, dementia, or other cognitive disorder
- ☐ Substance-Induced Mood Disorder (manic features)
- ☐ Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)
- ☐ Major Depressive Disorder – Single Episode
- ☐ Major Depressive Disorder – Recurrent
- ☐ Dysthymic Disorder
- ☐ Depressive Disorder NOS
- ☐ Bipolar I Disorder
- ☐ Bipolar II Disorder
- ☐ Cyclothymic Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Hypoactive Sexual Desire Disorder
- ☐ Dissociative Disorder
- ☐ Delusional Disorder (erotomania)
- ☐ Paraphilia
- ☐ Paraphilia NOS
- ☐ Sex Addiction
- ☐ Cybersex Addiction
- ☐ Gender Identity Disorder in Adults
- ☐ Sexual Disorder NOS
- ☐ Impulse-Control Disorder NOS
- ☐ Adjustment Disorder (disturbance of conduct)
- ☐ Borderline Personality Disorder
- ☐ Avoidant Personality Disorder
- ☐ Relational Problems
- ☐ Religious or Spiritual Problem
- ☐ Phase of Life Problem
- ☐ Unspecified Mental Disorder (nonpsychotic)

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 2 – Bill.

Bill tells you he has come to see you because he was has lost his marriage and is feeling depressed and suicidal. His pastor suggested Bill get some support coping with the loss of his marriage and referred Bill to you.

An electrician in his mid-20s, married for 3 years, Bill had masturbated nearly every night before going to sleep since his middle teens when he first discovered online porn pictures and videos. When he quit using alcohol and other drugs in his early 20s, his sexual fantasies and urges became more frequent and more intense. At about the same time his wife and his sister started commenting that Bill appeared to be depressed, moping about the house when home and not seeing his friends anymore.

He began to experience strong urges to masturbate in the morning, usually after having had a hard time getting to sleep, which was a frequent occurance. He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife. During these times, his wife and coworkers would notice and tell Bill to relax and that he was making them nervous because he was so jumpy. Consequently, he started to view online porn and masturbate before work, even though he would sometimes arrive late, dazed and zoned out as a result.

Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours. Bill would search for hours for sexual images, sorting them into meticulous categories and folders and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his private locker at work. When Bill would find the "perfect" image he would stop searching and masturbate to it.

No longer sufficiently excited by viewing porn online, Bill began to purchase online "live" strippers and "live" streaming videos of sexual acts. He wife caught him at home one day and told him if he didn't stop she would leave him, and he received a second warning about tardiness and inattentiveness at work. He felt disgusted with himself and started to have recurring thoughts of killing himself and escaping all the problems; but each time he tried to stop going online to surf for sex, he would fail.

Sexual images and fantasies accompanied by arousal would intrude into his consciousness throughout the day, whether he wanted them to or not, and he would feel as though he was going to explode. At night Bill was having difficulty sleeping, feeling jittery and unable to relax with sexual images swirling through his head. The only thing that would make them go away was logging back online to search for and look at more sex sites. He occasionally thought to himself that this was crazy and that he was stuck in a never-ending loop.

When his wife became pregnant, he deleted his collection of online pornography and his list of online favorites and resolved to quit masturbating. Within a few months, though, he again lost control of his online surfing and masturbation and the marriage soon fell apart. Before long he had "maxed-out" his credit cards. Socially isolated, deeply in debt, suicidal, and about to lose his job, Bill felt powerless.

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 2 – Question 1.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Bill).

A rating of '0' indicates that you believe the problem described to be ***Not at all contributing*** in the case above, while a rating of '4' indicates that you believe it to be ***A key contributor***.

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

0 1 2 3 4

2. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

3. Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

0 1 2 3 4

4. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

0 1 2 3 4

5. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

6. The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems

0 1 2 3 4

7. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

0 1 2 3 4

8. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

9. Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action

0 1 2 3 4

10. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

11. Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

12. Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind (not imposed from without as in thought insertion)

0 1 2 3 4

13. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

0 1 2 3 4

14. Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

15. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly

0 1 2 3 4

16. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

0 1 2 3 4

17. Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

18. Driven and repetitive behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connect in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

0 1 2 3 4

19. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

0 1 2 3 4

20. Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

21. Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

22. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

0 1 2 3 4

23. Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

24. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships

0 1 2 3 4

25. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

0 1 2 3 4

26. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

27. Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 2 – Question 2.

Instructions: From the list below, please select and rank the top 5 presenting problems you believe to be illustrated in preceding case (*Bill*).

A ranking of '1' means that you believe this to be the ***primary problem*** in need of therapeutic attention, while a ranking of '5' means that you believe this to be the ***most peripheral problem*** in need of the therapeutic attention.

- ☐ Delirium, dementia, or other cognitive disorder
- ☐ Substance-Induced Mood Disorder (manic features)
- ☐ Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)
- ☐ Major Depressive Disorder – Single Episode
- ☐ Major Depressive Disorder – Recurrent
- ☐ Dysthymic Disorder
- ☐ Depressive Disorder NOS
- ☐ Bipolar I Disorder
- ☐ Bipolar II Disorder
- ☐ Cyclothymic Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Hypoactive Sexual Desire Disorder
- ☐ Dissociative Disorder
- ☐ Delusional Disorder (erotomania)
- ☐ Paraphilia
- ☐ Paraphilia NOS
- ☐ Sex Addiction
- ☐ Cybersex Addiction
- ☐ Gender Identity Disorder in Adults
- ☐ Sexual Disorder NOS
- ☐ Impulse-Control Disorder NOS
- ☐ Adjustment Disorder (disturbance of conduct)
- ☐ Borderline Personality Disorder
- ☐ Avoidant Personality Disorder
- ☐ Relational Problems
- ☐ Religious or Spiritual Problem
- ☐ Phase of Life Problem
- ☐ Unspecified Mental Disorder (nonpsychotic)

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 3 – Jeff.

Jeff tells you he has come to see you because he is feeling very anxious about the hospital Chief of Staff's recommendation that he take some time off work and is worried about his career.

Jeff, a married neurologist in his 40s, feels tired and without energy all the time now. It doesn't seem to matter how much time he sets aside for sleep, he just never sleeps more than 2-3 hours a night. This has been going on for 2 months.

In his marriage, sex was among one of the main sources of tension. Jeff wanted to have sex with his wife every day, sometimes two or three times a day. He thought about having sex almost constantly, accompanied by feelings of intense nervousness that his wife would turn him down again if he asked. He knew his mind had worked this way since he was a young man. When she declined to have sex with Jeff, he felt desperate and feared that she did not love him, that he was not good enough for her, that she was tired of him and was preparing to leave him.

On such occasions, and sometimes to interrupt the almost constant thoughts of sex, he withdrew to his study and immersed himself in work, rechecking patient diagnoses. Sometimes for a few hours a night several times a week he would attempt to get his sexual needs met by reading online erotica and masturbating, but he did not seek sex elsewhere. Sometimes he felt guilty about looking online for sexual release but he didn't know what else to do.

When Jeff wasn't working and thinking about sex he was eating. In fact, he and his wife and colleagues had noticed that he had gained 10-15 lbs in the last month alone. When his wife's inflammatory bowel disease flared up, Jeff cared for her sensitively, and she expressed her appreciation and gratitude. At such times, Jeff felt needed and valued and rarely thought of sex. Jeff's desire for sex occasionally offended his wife, who felt then that he would rather have sex than talk with her. Sometimes when Jeff's wife complied with his requests for sex, she resented him.

Several of Jeff's colleagues had commented to him in the last couple of weeks that he didn't look his usual brisk self, and that he looked slowed down and depressed. The Chief of Staff had called Jeff into his office and indicated that perhaps Jeff should seek counselling from the hospital EAP, and maybe take some time off work after completing his backlog of incomplete patient charts.

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 3 – Question 1.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Jeff).

A rating of '0' indicates that you believe the problem described to be ***Not at all contributing*** in the case above, while a rating of '4' indicates that you believe it to be ***A key contributor***.

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

0 1 2 3 4

2. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

3. Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

0 1 2 3 4

4. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

0 1 2 3 4

5. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

6. The intrusive and inappropriate recurrent and persistent thoughts, impulses, or images are not simply excessive worries about real life problems

0 1 2 3 4

7. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

0 1 2 3 4

8. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

9. Attempts made to ignore or suppress such intrusive and inappropriate recurrent and persistent thoughts, impulses, or images, or to neutralize them with some other thought or action

0 1 2 3 4

10. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

11. Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

12. Recognizes that the intrusive and inappropriate recurrent and persistent obsessional thoughts, impulses, or images are the product of his/her own mind (not imposed from without as in thought insertion)

0 1 2 3 4

13. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

0 1 2 3 4

14. Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

15. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly

0 1 2 3 4

16. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

0 1 2 3 4

17. Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

18. Driven and repetitive behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connect in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

0 1 2 3 4

19. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

0 1 2 3 4

20. Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

21. Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

22. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

0 1 2 3 4

23. Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

24. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships

0 1 2 3 4

25. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

0 1 2 3 4

26. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

27. Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning)

0 1 2 3 4

Questionnaire #3

Your Anonymous ID#: ___ - ___ - ___ - ___
1 2 3 4

Case 3 – Question 2.

Instructions: From the list below, please select and rank the top 5 presenting problems you believe to be illustrated in preceding case (Jeff).

A ranking of '1' means that you believe this to be the ***primary problem*** in need of therapeutic attention, while a ranking of '5' means that you believe this to be the ***most peripheral problem*** in need of the therapeutic attention.

- ☐ Delirium, dementia, or other cognitive disorder
- ☐ Substance-Induced Mood Disorder (manic features)
- ☐ Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)
- ☐ Major Depressive Disorder – Single Episode
- ☐ Major Depressive Disorder – Recurrent
- ☐ Dysthymic Disorder
- ☐ Depressive Disorder NOS
- ☐ Bipolar I Disorder
- ☐ Bipolar II Disorder
- ☐ Cyclothymic Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Hypoactive Sexual Desire Disorder
- ☐ Dissociative Disorder
- ☐ Delusional Disorder (erotomania)
- ☐ Paraphilia
- ☐ Paraphilia NOS
- ☐ Sex Addiction
- ☐ Cybersex Addiction
- ☐ Gender Identity Disorder in Adults
- ☐ Sexual Disorder NOS
- ☐ Impulse-Control Disorder NOS
- ☐ Adjustment Disorder (disturbance of conduct)
- ☐ Borderline Personality Disorder
- ☐ Avoidant Personality Disorder
- ☐ Relational Problems
- ☐ Religious or Spiritual Problem
- ☐ Phase of Life Problem
- ☐ Unspecified Mental Disorder (nonpsychotic)

CVSI-V1 QUESTION 1 SUBSCALE SCORING PROTOCOLS

CVSI-V1 Q1 Cybersex Addiction (CSA) Subscale:

(1) Maintain the same coding of 0-4
(2) Compare scores for items #1 and #4 and select only the one score that is highest OR if the scores are the same only select one of them. This new selected score will be called “High score b/w item #1 and #4”.
(3) Compare scores for items #7 and #10 and select only the one score that is highest OR if the scores are the same only select one of them. This new selected score will be called “High score b/w item #7 and #10”.
(4) Add the outcome of steps 2 and 3 above
(5) Add together items #13, 16, 19, 22, and 25
(6) Add the outcome of steps 4 and 5 above
(7) A score on a continuum from 0-28 will be generated by this formula. Scores greater than or equal to 9 will indicate endorsement of the “diagnosis” of Cybersex Addiction. Scores less than 9 will indicate lack of endorsement of the “diagnosis” of Cybersex Addiction”.

CVSI-V1 Q1 Major Depressive Disorder (MDD) Subscale:

Note: IF (NEITHER criterion 1 endorsed at >=3 NOR criterion 2 endorsed at >=3) OR criterion C not endorsed at >= 3 THEN formula considered null and score of ‘0’ given for whole subscale; BUT IF (EITHER criterion 1 endorsed at >=3 OR criterion 2 endorsed at >=3) AND criterion C endorsed at >= 3 THEN formula = criteria 1 +2 +3 +4 +5 +6 +7 +8 +9 +C.

(1) Maintain the same coding of 0-4
(2) Check to see if item #2 was endorsed with a Likert rating of greater than or equal to 3
(3) Check to see if item #5 was endorsed with a Likert rating of greater than or equal to 3
(4) If the outcome of EITHER step 2 OR step 3 is true then proceed to step 5, if both are false then proceed to step 8
(5) Check to see if item #27 was endorsed with a Likert rating of greater than or equal to 3
(6) If the outcome of step 5 is true then proceed to step 7, if false then proceed to step 8
(7) If the outcome of step 4 AND step 6 are BOTH true then add together items #2, 5, 8, 11, 14, 17, 20, 23, 26 and 27 (i.e., MDD-SE Subscale Score = item#2 + item#5 + item#8 + item#11 + item#14 + item#17 + item#20 + item#23 + item#26 + item#27).

(8) If the outcome of EITHER step 4 OR step 6 are false then the formula is considered null and a score of ‘0’ is given for the whole subscale.

CVSI-V1 Q1 Obsessive-Compulsive Disorder (OCD) Subscale:

Obsessions:

Note: if criterion B AND C not endorsed at >= 3 then formula considered null and score of ‘0’ given for whole subscale.

(1) Maintain the same coding of 0-4
(2) Check to see if item #21 was endorsed with a Likert rating of greater than or equal to 3
(3) Check to see if item #24 was endorsed with a Likert rating of greater than or equal to 3
(4) If the outcome of BOTH step 2 AND step 3 is true then proceed to step 5, if EITHER is false then proceed to step 6
(5) If the outcome of step 4 is true then add together items #3, 6, 9, 12, 21 and 24 (i.e., OCD-Obsessions Subscale Score = item#3 + item#6 + item#9 + item#12 + item#21 + item#24).
(6) If the outcome of step 4 is false then the formula is considered null and a score of ‘0’ is given for the whole subscale.

Compulsions:

Note: if criterion B AND C not endorsed at >= 3 then formula considered null and score of ‘0’ given for whole subscale.

(1) Maintain the same coding of 0-4
(2) Check to see if item #21 was endorsed with a Likert rating of greater than or equal to 3
(3) Check to see if item #24 was endorsed with a Likert rating of greater than or equal to 3
(4) If the outcome of BOTH step 2 AND step 3 is true then proceed to step 5, if EITHER is false then proceed to step 6
(5) If the outcome of step 4 is true then add together items #15, 18, 21 and 24 (i.e., OCD-Compulsions Subscale Score = item#15 + item#18 + item#21 + item#24).
(6) If the outcome of step 4 is false then the formula is considered null and a score of ‘0’ is given for the whole subscale.

Appendix I

Major Depressive Disorder (MDD) Diagnostic Criteria

Major Depressive Disorder (MDD) – Single Episode

(APA, 2000, p. 356)

A. Presence of a single Major Depressive Episode

Major Depressive Episode Diagnostic Criteria

a. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change form previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
Note: In children and adolescents can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
Note: In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

b. The symptoms do not meet criteria for a Mixed Episode.

c. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

d. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

e. The symptoms are not better accounted for by Bereavement, i.e., after the

loss of a loved one, the symptoms persist for longer than 2 months or are characterized by a marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. **Note**: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

Appendix J

CSA Diagnostic Criteria by Case Vignette in CVSI-V1, CVSI-2 and CVSI-3

Cybersex Addiction (CSA)		Phase I: Pilot								Phase II: Study			
		Participants: PhD Students & Expert Validators #1 & #2				Participants: Expert Validator #3				Participants: Canadian Registered Psychologists			
Diagnostic criterion #	Diagnostic criterion label	Corresponding CVSI-V1 Q1 item #	Diagnostic criteria presented in each case vignette of CVSI-V1			Corresponding CVSI-V2 Q2 item # (Q1 in CVSI-V1 renamed Q2)	Diagnostic criteria presented in each case vignette of CVSI-V2			Corresponding CVSI-V3 Q2 item #	Diagnostic criteria presented in each case vignette of CVSI-V3		
			Case 1 (Sophie)	Case 2 (Bill)	Case 3 (Jeff)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)
A maladaptive pattern of online sexual behaviour, leading to clinically significant impairment or distress, as manifested by three (or more) of the following and occurring at any time in the same 12-month period.													
1) Tolerance, as defined by either of the following:													
1(a)	a need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect;	1	--	X	--	1	--	--	X	1	--	--	X
1(b)	markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity.	4	--	X	--	3	--	--	X	3	--	--	X
2) Withdrawal, as manifested by either of the following:													
2(a)	characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour,	7	--	X	--	5	--	--	X	5	--	--	X
2(b)	the same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms	10	--	X	--	7	--	--	X	7	--	--	X

Cybersex Addiction (CSA)		Phase I: Pilot								Phase II: Study		
		Participants: PhD Students & Expert Validators #1 & #2				Participants: Expert Validator #3				Participants: Canadian Registered Psychologists		
Diagnostic criterion #	Diagnostic criterion label	Corresponding CVSI-V1 Q1 item #	Diagnostic criteria presented in each case vignette of CVSI-V1			Corresponding CVSI-V2 Q2 item # (Q1 in CVSI-V1 renamed Q2)	Diagnostic criteria presented in each case vignette of CVSI-V2			Corresponding CVSI-V3 Q2 item #	Diagnostic criteria presented in each case vignette of CVSI-V3		
			Case 1 (Sophie)	Case 2 (Bill)	Case 3 (Jeff)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)
3	The online sexual behaviour is often engaged in over a longer period, in greater quantity or at a higher level of intensity than was intended.	13	--	X	--	9	--	--	X	9	--	--	X
4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour	16	X	X	--	11	--	X	X	11	--	X	X
5	A great deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour or to recover from its effects.	19	X	X	X	13	X	X	X	13	--	X	X
6	Important social, occupational or recreational activities are given up or reduced because of the online sexual behaviour.	22	X	X	--	15	--	X	X	15	--	X	X
7	The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences.	25	X	X	X	17	X	X	X	17	X	--	X

Appendix K

MDD Diagnostic Criteria by Case Vignette in CVSI-V1, CVSI-2 and CVSI-V3

Major Depressive Disorder (MDD)		Phase I: Pilot								Phase II: Study		
		Participants: PhD Students & Expert Validators #1 & #2				Participants: Expert Validator #3				Participants: Canadian Registered Psychologists		
Diagnostic criterion #	Diagnostic criterion label	Corresponding CVSI-V1 Q1 item #	Diagnostic criteria presented in each case vignette of CVSI-V1			Corresponding CVSI-V2 Q2 item # (Q1 in CVSI-V1 renamed Q2)	Diagnostic criteria presented in each case vignette of CVSI-V2			Corresponding CVSI-V3 Q2 item #	Diagnostic criteria presented in each case vignette of CVSI-V3		
			Case 1 (Sophie)	Case 2 (Bill)	Case 3 (Jeff)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)
A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. *Note:* Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.													
1)	depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).	2	--	X	X	2	X	X	X	2	X	X	X
2)	markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)	5	X	--	--	6	X	X	X	6	X	X	X
3)	significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.	8	X	--	X	8	X	X	X	8	X	X	X
4)	insomnia or hypersomnia nearly every day	11	X	X	X	10	X	X	X	10	X	X	X
5)	psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)	14	--	X	X	12	X	X	X	12	X	X	X

Major Depressive Disorder (MDD)		Phase I: Pilot								Phase II: Study			
		Participants: PhD Students & Expert Validators #1 & #2				Participants: Expert Validator #3				Participants: Canadian Registered Psychologists			
Diagnostic criterion #	Diagnostic criterion label	Corresponding CVSI-V1 Q1 item #	Diagnostic criteria presented in each case vignette of CVSI-V1			Corresponding CVSI-V2 Q2 item # (Q1 in CVSI-V1 renamed Q2)	Diagnostic criteria presented in each case vignette of CVSI-V2			Corresponding CVSI-V3 Q2 item #	Diagnostic criteria presented in each case vignette of CVSI-V3		
			Case 1 (Sophie)	Case 2 (Bill)	Case 3 (Jeff)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)
6)	fatigue or loss of energy nearly every day	17	--	--	X	16	X	X	X	16	X	X	X
7)	feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)	20	X	--	--	--	--	--	--	--	--	--	--
8)	diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)	23	X	X	--	--	--	--	--	--	--	--	--
9)	recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide	26	--	X	--	18	X	X	X	18	X	X	X
B.	The symptoms do not meet criteria for a Mixed Episode.	--	--	--	--	--	--	--	--	--	--	--	--
C.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	27	--	--	X	--	X	X	X	--	X	X	X
D.	The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).	--	--	--	--	--	--	--	--	--	--	--	--
E.	The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by a marked functional	--	--	--	--	--	--	--	--	--	--	--	--

Appendix L

OCD Diagnostic Criteria by Case Vignette in CVSI-V1, CVSI-2 and CVSI-V3

Obsessive Compulsive Disorder (OCD)															
		Phase I: Pilot								Phase II: Study					
		Participants: PhD Students & Expert Validators #1 & #2				Participants: Expert Validator #3				Participants: Canadian Registered Psychologists					
Diagnostic criterion #	Diagnostic criterion label	Corresponding CVSI-V1 Q1 item #	Diagnostic criteria presented in each case vignette of CVSI-V1			Corresponding CVSI-V2 Q2 item # (Q1 in CVSI-V1 renamed Q2)	Diagnostic criteria presented in each case vignette of CVSI-V2			Corresponding CVSI-V3 Q2 item #	Diagnostic criteria presented in each case vignette of CVSI-V3				
			Case 1 (Sophie)	Case 2 (Bill)	Case 3 (Jeff)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)		
A. Either obsessions or compulsions:															
Obsessions as defined by (1), (2), (3), and (4):															
A(ob1)	recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress	3	--	X	X	4	X	X	X	4	X	X	X		X
A(ob2)	the thoughts, impulses, or images are not simply excessive worries about real-life problems	6	--	X	--	--	X	X	X	--	X	X	X		X
A(ob3)	the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action	9	--	X	X	--	X	X	X	--	X	X	X		X
A(ob4)	the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)	12	--	X	X	--	X	X	X	--	X	X	X		X
Compulsions as defined by (1) and (2):															
A(com1)	repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly	15	X	X	--	14	X	X	X	14	X	X	X		X
A(com2)	the behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive	18	X	--	--	--	X	X	X	--	X	X	X		X

Obsessive Compulsive Disorder (OCD)		Phase I: Pilot								Phase II: Study		
		Participants: PhD Students & Expert Validators #1 & #2				Participants: Expert Validator #3				Participants: Canadian Registered Psychologists		
Diagnostic criterion #	Diagnostic criterion label	Corresponding CVSI-V1 Q1 item #	Diagnostic criteria presented in each case vignette of CVSI-V1			Corresponding CVSI-V2 Q2 item # (Q1 in CVSI-V1 renamed Q2)	Diagnostic criteria presented in each case vignette of CVSI-V2			Corresponding CVSI-V3 Q2 item #	Diagnostic criteria presented in each case vignette of CVSI-V3		
			Case 1 (Sophie)	Case 2 (Bill)	Case 3 (Jeff)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)		Case 1 (Jeff)	Case 2 (Sophie)	Case 3 (Bill)
B	At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. *Note*: This does not apply to children.	21	X	X	--	--	X	X	X	--	X	X	X
C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.	24	X	X	--	--	X	X	X	--	X	X	X
D	If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).	--	--	--	--	--	--	--	--	--	--	--	--
E	The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	--	--	--	--	--	--	--	--	--	--	--	--

Appendix M

CVSI-V1 Case Construction to Reflect CSA, MDD and OCD Diagnostic Criteria

CVSI-V1 CASE CONSTRUCTION

Case 1 – Sophie.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of anger possible indicate unresolved trauma work or BPD.	Sophie tells you she has come to see you because she has lost her job recently and is experiencing intense anger about this
	Suggestions of adjustment disorder.	and is having difficulty letting it go and moving on to search for other work.
		Her executive recruiter told her to get some help with her anger.
		Paragraph 2
		A single executive in her mid-30s, Sophie would say with a smile that her Achilles' heel was her "weakness for good-looking men".
		When an attractive man indicated to Sophie that he was interested in her sexually, she found herself unable to resist, or more accurately, she found herself unable to want to resist.
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side	She experienced herself almost as a victim, sexually drawn to men against her will.

	of the force", p. 115)	
	History of sexual abuse. Suggestion of possible PTSD.	It felt similar to when her swim coach used to flirt with her when she was 13. He ultimately ended up sexually abusing Sophie repeatedly.
		Paragraph 3
		When Sophie discovered online chat groups she suddenly had access to all sorts of men online who seemed to be interested in being sexual with her.
MDD criterion #2	Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Her friends said it was the only time they saw her show any interest in anything these days given how bored she had been saying she was with everything in her life.
		She began emailing back and forth with several men whom she had never met before but had encountered on the Internet chat groups.
		It escalated.
		Paragraph 4
		Over a few weeks she began spending 4-5 hours during the workday checking and responding to her email.
		Soon she and various men online began to instant message (IM) each other.

OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	In this way they became constantly available to each other online throughout the workday
		She went to her office earlier and stayed at work later so she could stay online later.
		Then it became weekends too.
OCD criterion #A1 (compulsions)	Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly (APA, 2000, DSM-IV-TR, p.462)	In some ways she felt she had to be tapped into what was happening online in these chat groups at all times,
OCD criterion #A2 (compulsions)	Behaviors or mental acts described in item #24 are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connect in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	otherwise she felt upset and anxious.
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day	She started losing lots of weight very quickly, but she reasoned it was because she had been working so hard.

	(during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	She barely slept, staying up all night composing emails in her head or fantasizing about what might happen if she met any of the online men in person.
		Paragraph 5
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When some of the men she was communicating with online started asking to meet with her, Sophie, again, found herself unable to say "no."
		She began meeting with the men over her lunch hour.
		Meetings in coffee shops became meetings in her apartment and rapidly progressed from flirtations to sex.
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	At first Sophie felt guilty about having sex with men she hardly knew at all but she brushed these feelings aside telling herself she was a modern woman.

CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	Sophie's fiancé ended their engagement after she repeatedly broke promises to him that she would stop sleeping with other men.
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	After the breakup Sophie felt worthless and terribly guilty for months, but this did not stop her from continuing to meet with the men from online.
		Paragraph 6
CSA criterion #5	A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	When Sophie began to use her apartment in the city for midday sexual liaisons, her lunch breaks stretched longer and longer.
CSA criterion #6	Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	Her formerly superior work performance began to slacken and she did not receive an expected promotion.
MDD criterion #8	Diminished ability to think or concentrate, or	At work, Sophie had a hard time thinking or concentrating on the

	indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	tasks in front of her.
		Sophie's boss warned her that she could lose her job if she was unable to keep business and personal separate in her life.
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	Sophie resolved that she would turn over a new leaf and for six weeks she kept her sexual behaviour in check, disconnected her internet access at work and stopped visiting the online chat groups.
		Paragraph 7
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	Then, when she was working late one night and had just finished a big project, she noticed that her neck and back were tight, and told herself she would just unwind a little with a quick visit to the online chat group.
OCD criterion #B	Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder (APA, 2000, DSM-IV-TR, p. 462)	As she logged in, in the back of her mind, a tiny thought that her need to go online felt too strong was quickly quieted.
		Within minutes she was instant messaged by one of the men online for a sexual rendezvous.
		Since there was no one at the

		office at this late hour, Sophie justified that it would be alright.
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When a male co-worker walked in on her sexual activities, Sophie knew their might be repercussions, yet she continued to liaise with men from the online chat group during her lunch hours.
		At the same time the co-worker who had walked in on Sophie began to pressure her for sexual favours.
		When she brushed him off, he disclosed to the boss Sophie's after hours office activities.
		Since this was against company policy, she was fired immediately.

Case 2 – Bill.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of depression w/ suicidality.	Bill tells you he has come to see you because he was has lost his marriage and is feeling depressed and suicidal.
	Suggestions of adjustment disorder.	His pastor suggested Bill get some support coping with the loss of his marriage and referred Bill to you.
		Paragraph 2
		An electrician in his mid-20s, married for 3 years, Bill had masturbated nearly every night

		before going to sleep since his middle teens when he first discovered online porn pictures and videos.
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When he quit using alcohol and other drugs in his early 20s, his sexual fantasies and urges became more frequent and more intense.
MDD criterion #1	Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	At about the same time his wife and his sister started commenting that Bill appeared to be depressed, moping about the house when home and not seeing his friends anymore.
		Paragraph 3
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	He began to experience strong urges to masturbate in the morning, usually after having had a hard time getting to sleep, which was a frequent occurrence.
CSA criteria #2a & 2b	(2a) characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour, (2b) the same (or closely	He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife.

	related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	
MDD criterion #5	Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	During these times, his wife and coworkers would notice and tell Bill to relax and that he was making them nervous because he was so jumpy.
CSA criterion #3	The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Consequently, he started to view online porn and masturbate before work,
MDD criterion #5	Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	even though he would sometimes arrive late, dazed and zoned out as a result.
		Paragraph 4
CSA criteria #1a & 1b	(1a) a need for markedly increased amount of intensity of the online sexual behaviour to	Some months later, Bill began to daily use the one company computer to search for and view

	achieve the desired effect, (1b) markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	porn
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	and masturbate at work as well, sometimes for hours.
OCD criterion #A1 (compulsions)	Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (APA, 2000, DSM-IV-TR, p. 462)	Bill would search for hours for sexual images, sorting them into meticulous categories and folders and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his private locker at work. When Bill would find the "perfect" image he would stop searching and masturbate to it.
		Paragraph 5
CSA criteria #1a & 1b	(1a) a need for markedly increased amount of intensity of the online sexual behaviour to achieve the desired effect, (1b) markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity. (Goodman, A. (1998) as	No longer sufficiently excited by viewing porn online, Bill began to purchase online "live" strippers and "live" streaming videos of sexual acts.

	cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	
CSA criterion #6	Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	His wife caught him at home one day and told him if he didn’t stop she would leave him,
MDD criterion #8	Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	and he received a second warning about tardiness and inattentiveness at work.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	He felt disgusted with himself and started to have recurring thoughts of killing himself and escaping all the problems;
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	but each time he tried to stop going online to surf for sex, he would fail.

		Paragraph 6
CSA criterion #5	A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Sexual images and fantasies accompanied by arousal would intrude into his consciousness throughout the day,
OCD criteria #A1 & A2 (obsessions)	(A1) Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress, (A2) The recurrent and persistent thoughts, impulses, or images as described in item #20 are not simply excessive worries about real life problems (APA, 2000, DSM-IV-TR, p. 462)	whether he wanted them to or not, and he would feel as though he was going to explode.
		At night Bill was having difficulty sleeping, feeling jittery and unable to relax with sexual images swirling through his head.
OCD criterion #A3 (obsessions)	Attempts made to ignore or suppress such thoughts, impulses, or images as described in item #20, or to neutralize them with some other thought or action (APA, 2000, DSM-IV-TR, p. 462)	The only thing that would make them go away was logging back online to search for and look at more sex sites.
OCD criteria #A4 (obsessions) & B	(A4) Recognizes that the obsessional thoughts, impulses, or images as described in item #20 are	He occasionally thought to himself that this was crazy and that he was stuck in a never-ending loop.

	the product of his/her own mind (not imposed from without as in thought insertion), (B) Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder (APA, 2000, DSM-IV-TR, p. 462)	
		Paragraph 7
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	When his wife became pregnant, he deleted his collection of online pornography and his list of online favorites and resolved to quit masturbating. Within a few months, though, he again lost control of his online surfing and masturbation and the marriage soon fell apart.
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	Before long he had "maxed-out" his credit cards.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Socially isolated, deeply in debt, suicidal, and about to lose his job, Bill felt powerless.

Case 3 – Jeff.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of anxiety but as a secondary symptom to the consequences of his depression.	Jeff tells you he has come to see you because he is feeling very anxious about the hospital Chief of Staff's recommendation that he take some time off work and is worried about his career
		Paragraph 2
MDD criterion #6	Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Jeff, a married neurologist in his 40s, feels tired and without energy all the time now.
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	It doesn't seem to matter how much time he sets aside for sleep, he just never sleeps more than 2-3 hours a night.
		This has been going on for 2 months.
		Paragraph 3
		In his marriage, sex was among one of the main sources of tension.
CSA criterion #5	A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover	Jeff wanted to have sex with his wife every day, sometimes two or three times a day.

	from its effects. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	
OCD criterion #A1 (obsessions)	Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress (APA, 2000, DSM-IV-TR, p. 462)	He thought about having sex almost constantly, accompanied by feelings of intense nervousness that his wife would turn him down again if he asked.
OCD criterion #A4 (obsessions)	Recognizes that the obsessional thoughts, impulses, or images as described in item #20 are the product of his/her own mind (not imposed from without as in thought insertion) (APA, 2000, DSM-IV-TR, p. 462)	He knew his mind had worked this way since he was a young man.
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When she declined to have sex with Jeff, he felt desperate and feared that she did not love him, that he was not good enough for her, that she was tired of him and was preparing to leave him.
		Paragraph 4
OCD criterion #A3 (obsessions)	Attempts made to ignore or suppress such thoughts, impulses, or images as described in item #20, or to neutralize them with some other thought or action (APA, 2000, DSM-	On such occasions, and sometimes to interrupt the almost constant thoughts of sex, he withdrew to his study and immersed himself in work, rechecking patient diagnoses

	IV-TR, p. 462)	
		Sometimes for a few hours a night several times a week he would attempt to get his sexual needs met by reading online erotica and masturbating, but he did not seek sex elsewhere.
		Sometimes he felt guilty about looking online for sexual release but he didn't know what else to do.
		Paragraph 5
		When Jeff wasn't working and thinking about sex he was eating.
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	In fact, he and his wife and colleagues had noticed that he had gained 10-15 lbs in the last month alone.
		When his wife's inflammatory bowel disease flared up, Jeff cared for her sensitively, and she expressed her appreciation and gratitude.
		At such times, Jeff felt needed and valued and rarely thought of sex.
		Jeff's desire for sex occasionally offended his wife, who felt then that he would rather have sex than talk with her.
		Sometimes when Jeff's wife complied with his requests for

		sex, she resented him.
		Paragraph 6
MDD criterion #5	Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Several of Jeff's colleagues had commented to him in the last couple of weeks that he didn't look his usual brisk self, and that he looked slowed down
MDD criterion #1	Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	and depressed.
MDD criterion #C	Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	The Chief of Staff had called Jeff into his office and indicated that perhaps Jeff should seek counselling from the hospital EAP, and maybe take some time off work after completing his backlog of incomplete patient charts.

Appendix N

CVSI-V2 Case Construction to Reflect CSA, MDD and OCD Diagnostic Criteria

CVSI-V2 CASE CONSTRUCTION

Case 1 – Jeff.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of anxiety but as a secondary symptom to the consequences of his depression.	Jeff tells you he has come to see you because he is feeling very anxious about the hospital Chief of Staff's recommendation that he take some time off work and is worried about his career.
MDD criterion #6	Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Jeff, a married neurologist in his 40s, feels tired, without energy,
MDD criterion #8	Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) (APA, 2000, DSM-IV-TR, p. 356)	and is having difficulty concentrating all the time now.
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	It doesn't seem to matter how much time he sets aside for sleep, he just never sleeps more than 2-3 hours a night. This has been going on for 2 months.
		Paragraph 2
		In his marriage, sex was among one of the main sources of tension.
CSA criterion #5	A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Jeff wanted to have sex with his wife every day, sometimes two or three times a day.
OCD criterion # A2 (obsessions)	The thoughts, impulses, or images are not simply excessive worries about real-life problems (APA, 2000,	He thought and fantasized about it obsessively.

	DSM-IV-TR, p. 462)	
MDD criterion #2	Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) (APA, 2000, DSM-IV-TR, p. 356)	His wife said he seemed to have lost interest in anything else.
OCD criterion #A1 (obsessions)	Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress (APA, 2000, DSM-IV-TR, p. 462)	He thought about having sex almost constantly, accompanied by feelings of intense nervousness that his wife would turn him down again if he asked.
OCD criterion #A1 (compulsions)	Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (APA, 2000, DSM-IV-TR, p. 462)	Jeff had grown up Catholic and every time he had a fantasy pop into his head he would mentally run through the Lord's prayer
OCD criterion #A2 (compulsions)	The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	in hopes that it would stop the sexual thoughts intruding into his head and reduce his urge to have sex.
OCD criterion #A4 (obsessions)	Recognizes that the obsessional thoughts, impulses, or images as described in item #20 are the product of his/her own mind (not imposed from without as in thought insertion) (APA, 2000, DSM-IV-TR, p. 462)	He knew his mind had worked this way since he was a young man.

OCD criterion #B	At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable (APA, 2000, DSM-IV-TR, p. 462)	Growing up and even now he often had the feeling that he was struggling with these thoughts more than his other male friends.
		Paragraph 3
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When Jeff's wife declined to have sex with him, he felt desperate and feared that she did not love him, that he was not good enough for her, that she was tired of him and was preparing to leave him.
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (APA, 2000, DSM-IV-TR, p. 356)	Jeff was spending a lot of time feeling intensely guilty nearly every day about his desire for sex.
OCD criterion #A3 (obsessions)	Attempts made to ignore or suppress such thoughts, impulses, or images as described in item #20, or to neutralize them with some other thought or action (APA, 2000, DSM-IV-TR, p. 462)	On such occasions, and sometimes to interrupt
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	the almost constant thoughts of sex, he withdrew to his study and immersed himself in work, rechecking patient diagnoses.
		Sometimes for a few hours a night several times a week he would attempt to get his sexual needs met by reading online erotica and

		masturbating, but he did not seek sex elsewhere.
		Sometimes he felt guilty about looking online for sexual release but he didn't know what else to do.
		Paragraph 4
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	When Jeff wasn't working and thinking about sex he was eating. In fact, he and his wife and colleagues had noticed that he had gained 10-15 lbs in the last month alone.
		When his wife's inflammatory bowel disease flared up, Jeff cared for her sensitively, and she expressed her appreciation and gratitude. At such times, Jeff felt needed and valued and rarely thought of sex. Jeff's desire for sex occasionally offended his wife, who felt then that he would rather have sex than talk with her. Sometimes when Jeff's wife complied with his requests for sex, she resented him.
MDD criterion # 9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (APA, 2000, DSM-IV-TR, p. 356)	At those times Jeff would think a lot about dying and
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p.	the sense of relief it might bring from the cycle of misery he felt he was in. He never did anything about it though.

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		Paragraph 5
MDD criterion #5	Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Several of Jeff's colleagues had commented to him in the last couple of weeks that he didn't look his usual brisk self, and that he looked slowed down
MDD criterion #1	Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	and depressed.
MDD criterion #C	Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	The Chief of Staff had called Jeff into his office and indicated that perhaps Jeff should seek counselling from the hospital EAP, and maybe take some time off work after completing his backlog of incomplete patient charts.

Case 2 – Sophie.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of anger possible indicate unresolved trauma work or BPD.	Sophie tells you she has come to see you because she has lost her job recently and is experiencing intense daily anger
MDD criterion #1	Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears	and sadness about this and

	tearful) (APA, 2000, DSM-IV-TR, p. 356)	
	Suggestions of adjustment disorder.	is having difficulty letting it go and
MDD criterion #C	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000, DSM-IV-TR, p. 356)	moving on to search for other work.
		Her executive recruiter told her to get some help with her anger.
		Paragraph 2
		A single executive in her mid-30s, Sophie would say with a smile that her Achilles' heel was her "weakness for good-looking men". When an attractive man indicated to Sophie that he was interested in her sexually, she found herself unable to resist, or more accurately, she found herself unable to want to resist.
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	She experienced herself almost as a victim, sexually drawn to men against her will.
		It felt similar to when her swim coach used to flirt with her when she was 13.
		Paragraph 3
		When Sophie discovered online chat groups she suddenly had access to all sorts of men online who seemed to be interested in being sexual with her.
MDD criterion #2	Markedly diminished interest or pleasure in all, or almost all, activities most of the day,	Her friends said it was the only time they saw her show any interest in anything these days given how

	nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	bored she had been saying she was with everything in her life.
		She began emailing back and forth with several men whom she had never met before but had encountered on the Internet chat groups.
		It escalated.
		Paragraph 4
		Over a few weeks she began spending 4-5 hours during the workday checking and responding to her email. Soon she and various men online began to instant message (IM) each other.
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	In this way they became constantly available to each other online throughout the workday.
		She went to her office earlier and stayed at work later so she could stay online later. Then it became weekends too.
OCD criterion #A1 (compulsions)	Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly (APA, 2000, DSM-IV-TR, p. 462)	In some ways she felt she had to be tapped into what was happening online in these chat groups at all times,
OCD criterion #A2 (compulsions)	Behaviors or mental acts described in item #24 are aimed at preventing or reducing distress or	otherwise she felt upset and anxious.

	preventing some dreaded event or situation; however, these behaviors or mental acts either are not connect in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	When she started losing lots of weight very quickly she reasoned it was because she had been working so hard.
MDD criterion #5	Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (APA, 2000, DSM-IV-TR, p. 356)	Her friend told her she seemed restless and fidgety all the time now,
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	and she barely slept.
		Instead she would stay up all night composing emails in her head or fantasizing about what might happen if she met any of the online men in person.
MDD criterion #6	Fatigue or loss of energy nearly every day (APA, 2000, DSM-IV-TR, p. 356)	As a result Sophie felt exhausted almost every day.
		Paragraph 5
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge	When some of the men she was communicating with online started asking to meet with her, Sophie, again, found herself unable to say “no”.

	of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	
		She began meeting with the men over her lunch hour. Meetings in coffee shops became meetings in her apartment and rapidly progressed from flirtations to sex.
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	At first Sophie felt guilty about having sex with men she hardly knew at all but she brushed these feelings aside telling herself she was a modern woman.
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Sophie's fiancé ended their engagement after she repeatedly broke promises to him that she would stop sleeping with other men.
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	After the breakup Sophie felt worthless and terribly guilty for months, but this did not stop her from continuing to meet with the men from online.
		Paragraph 6
CSA criterion #5	A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When Sophie began to use her apartment in the city for midday sexual liaisons, her lunch breaks stretched longer and longer.

CSA criterion #6	Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	Her formerly superior work performance began to slacken and she did not receive an expected promotion.
MDD criterion #8	Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	At work, Sophie had a hard time thinking or concentrating on the tasks in front of her.
OCD criterion #A1 (obsessions) & #A2 (obsessions)	(A1) Obsessions as defined by - recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress, (A2) The thoughts, impulses, or images are not simply excessive worries about real-life problems (APA, 2000, DSM-IV-TR, p. 462)	She was frequently bothered by intruding graphic sexual images
OCD criterion #A4 (obsessions)	The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion) (APA, 2000, DSM-IV-TR, p. 462)	from her online chats,
OCD criterion #A3 (obsessions)	The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action (APA, 2000, DSM-IV-TR, p. 462)	which she would then try to ignore.
		Sophie's boss warned her that she could lose her job if she was unable to keep business and personal separate in her life.

CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Sophie resolved that she would turn over a new leaf and for six weeks she kept her sexual behaviour in check, disconnected her internet access at work and stopped visiting the online chat groups.
		Paragraph 7
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Then, when she was working late one night and had just finished a big project, she noticed that her neck and back were tight, and told herself she would just unwind a little with a quick visit to the online chat group.
OCD criterion #B	Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder (APA, 2000, DSM-IV-TR, p. 462)	As she logged in, in the back of her mind, a tiny thought that her need to go online felt too strong was quickly quieted.
		Within minutes she was instant messaged by one of the men online for a sexual rendezvous. Since there was no one at the office at this late hour, Sophie justified that it would be alright.
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When a male co-worker walked in on her sexual activities, Sophie knew their might be repercussions, yet she continued to liaise with men from the online chat group during her lunch hours.
		At the same time the co-worker who had walked in on Sophie began to pressure her for sexual favours. When she brushed him off, he disclosed to the boss Sophie's after hours office activities. Since this was against company policy, she was fired immediately.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific	Since being fired Sophie has been having frequent intrusive thoughts about killing herself by driving her car off the road.

	plan for committing suicide (APA, 2000, DSM-IV-TR, p. 356)	

Case 3 – Bill.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of depression with suicidality.	Bill tells you he has come to see you because he was has lost his marriage and is feeling depressed and suicidal.
	Suggestions of adjustment disorder.	His pastor suggested Bill get some support coping with the loss of his marriage and referred Bill to you.
		Paragraph 2
		An electrician in his mid-20s, married for 3 years, Bill had masturbated nearly every night before going to sleep since his middle teens when he first discovered online porn pictures and videos.
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When he quit using alcohol and other drugs in his early 20s, his sexual fantasies and urges became more frequent and more intense.
MDD criterion #1	Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	At about the same time his wife and his sister started commenting that Bill appeared to be depressed
MDD criterion #2	Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly	and uninterested in the things he used to do, moping about the house when home and not seeing

	every day (as indicated by either subjective account or observation made by others) (APA, 2000, DSM-IV-TR, p. 356)	his friends anymore.
		Paragraph 3
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	He began to experience strong urges to masturbate in the morning, usually after having had a hard time getting to sleep, which was a frequent occurrence.
OCD criterion #A2 (compulsions)	The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife.
CSA criteria #2a & 2b	(2a) Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour, (2b) The same (or closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife.
MDD criterion #5	Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	During these times, his wife and coworkers would notice and tell Bill to relax and that he was making them nervous because he was so jumpy.

CSA criterion #3	The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Consequently, he started to view online porn and masturbate before work, even though he would sometimes arrive late,
MDD criterion #5	Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	dazed and zoned out as a result.
		Paragraph 4
CSA criteria #1a & 1b	(1a) A need for markedly increased amount of intensity of the online sexual behaviour to achieve the desired effect, (1b) Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours.
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours.
OCD criterion #A1 (compulsions) & #A2 (compulsions)	(A1) Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or	Bill would search for hours for sexual images, sorting them into meticulous categories and folders and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his

	according to rules that must be applied rigidly, (A2) The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	private locker at work. As he searched he would become more and more tense but the organizing of the images seemed to soothe him. When Bill would find the "perfect" image he would stop searching and masturbate to it.
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (APA, 2000, DSM-IV-TR, p. 356)	The process so consumed him that he lost interest in food.
		Paragraph 5
		No longer sufficiently excited by viewing porn online, Bill began to purchase online "live" strippers and "live" streaming videos of sexual acts.
OCD criteria #A1 (obsessions) and A2 (obsessions)	(A1) Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress, (A2) The thoughts, impulses, or images are not simply excessive worries about real-life problems (APA, 2000, DSM-IV-TR, p. 462)	He couldn't stop thinking about porn and what he'd seen online even when he so desperately wanted to pay attention to his wife.
CSA criterion #6	Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	His wife caught him watching "live" porn at home one day and told him if he didn't stop she would leave him.
MDD criterion #8	Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by	He also received a second warning about tardiness and

	subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	inattentiveness at work.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	He felt disgusted with himself and started to have recurring thoughts of killing himself and escaping all the problems;
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	but each time he tried to stop going online to surf for sex, he would fail.
		Paragraph 6
CSA criterion #5	A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Sexual images and fantasies accompanied by arousal would intrude into his consciousness throughout the day,
OCD criteria #A1 (obsessions) & A2 (obsessions)	(A1) Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress, (A2) The recurrent and persistent thoughts, impulses, or images as described in item #20 are not simply excessive worries about real life problems (APA, 2000, DSM-IV-TR, p. 462)	whether he wanted them to or not, and he would feel as though he was going to explode.
MDD criterion #6	Fatigue or loss of energy nearly every day (APA, 2000, DSM-	At night Bill was having difficulty sleeping, feeling jittery and unable to relax with sexual

	IV-TR, p. 356)	images swirling through his head, resulting in exhaustion during the day.
OCD criterion #A3 (obsessions)	Attempts made to ignore or suppress such thoughts, impulses, or images as described in item #20, or to neutralize them with some other thought or action (APA, 2000, DSM-IV-TR, p. 462)	The only thing that would make them go away was logging back online to search for and look at more sex sites.
OCD criteria #A4 (obsessions) & B	(A4) Recognizes that the obsessional thoughts, impulses, or images as described in item #20 are the product of his/her own mind (not imposed from without as in thought insertion), (B) Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder (APA, 2000, DSM-IV-TR, p. 462)	He occasionally thought to himself that this was crazy and that he was stuck in a never-ending loop.
		Paragraph 7
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	When his wife became pregnant, he deleted his collection of online pornography and his list of online favorites and resolved to quit masturbating. Within a few months, though, he again lost control of his online surfing and masturbation and the marriage soon fell apart.
		Before long he had "maxed-out" his credit cards.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Socially isolated, deeply in debt, suicidal,
MDD criterion #C	The symptoms cause clinically significant distress or impairment in social,	and about to lose his job,

	occupational, or other important areas of functioning (APA, 2000, DSM-IV-TR, p. 356)	
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (APA, 2000, DSM-IV-TR, p. 356)	Bill felt powerless and worthless.

Appendix O

CVSI-V3 Case Construction to Reflect CSA, MDD and OCD Diagnostic Criteria

CVSI-V3 CASE CONSTRUCTION

Case 1 – Jeff.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of anxiety but as a secondary symptom to the consequences of his depression.	Jeff tells you he has come to see you because he is feeling very anxious about the hospital Chief of Staff's recommendation that he take some time off work and is worried about his career.
MDD criterion #6	Fatigue or loss of energy nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Jeff, a married neurologist in his 40s, feels tired, without energy,
MDD criterion #8	Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) (APA, 2000, DSM-IV-TR, p. 356)	and is having difficulty concentrating all the time now.
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	It doesn't seem to matter how much time he sets aside for sleep, he just never sleeps more than 2-3 hours a night. This has been going on for 2 months.
		Paragraph 2
		In his marriage, sex was among one of the main sources of tension.
OCD criterion #A2 (obsessions)	The thoughts, impulses, or images are not simply excessive worries about real-life problems (APA, 2000, DSM-IV-TR, p. 462)	He thought and fantasized about it all the time.
MDD criterion #2	Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective	His wife said he seemed to have lost interest in the things he used to enjoy.

	account or observation made by others) (APA, 2000, DSM-IV-TR, p. 356)	
OCD criterion #A1 (obsessions)	Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress (APA, 2000, DSM-IV-TR, p. 462)	He thought about having sex almost constantly, accompanied by feelings of intense nervousness that his wife would turn him down again if he asked.
OCD criterion #A1 (compulsions)	Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (APA, 2000, DSM-IV-TR, p. 462)	Jeff had grown up Catholic and every time he had a fantasy pop into his head he would mentally run through the Lord's prayer
OCD criterion #A2 (compulsions)	The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	in hopes that it would stop the sexual thoughts intruding into his head and reduce his urge to have sex.
OCD criterion #A4 (obsessions)	Recognizes that the obsessional thoughts, impulses, or images as described in item #20 are the product of his/her own mind (not imposed from without as in thought insertion) (APA, 2000, DSM-IV-TR, p. 462)	He knew his mind had worked this way since he was a young man.
OCD criterion #B	At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable (APA, 2000,	Growing up and even now he often had the feeling that he was struggling with these thoughts more than his other male friends.

	DSM-IV-TR, p. 462)	
		Paragraph 3
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Just like with previous girlfriends, Jeff often felt desperate and feared that his wife did not love him and that he was not good enough for her. These feelings were even more present when his wife declined sex.
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (APA, 2000, DSM-IV-TR, p. 356)	Jeff was spending a lot of time feeling intensely guilty nearly every day about his desire for sex.
OCD criterion #A3 (obsessions)	Attempts made to ignore or suppress such thoughts, impulses, or images as described in item #20, or to neutralize them with some other thought or action (APA, 2000, DSM-IV-TR, p. 462)	On such occasions, and sometimes to interrupt
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	the almost constant thoughts of sex, he withdrew to his study and immersed himself in work, rechecking patient diagnoses.
		Sometimes for a few hours a night several times a week he would attempt to get his sexual needs met by reading online erotica and masturbating, but he did not seek sex elsewhere.
		Sometimes he felt guilty about looking online for sexual release but he didn't know what else to

		do.
		Paragraph 4
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	When Jeff wasn't working and thinking about sex he was eating. In fact, he and his wife and colleagues had noticed that he had gained 10-15 lbs in the last month alone.
		When his wife's inflammatory bowel disease flared up, Jeff cared for her sensitively, and she expressed her appreciation and gratitude. At such times, Jeff felt needed and valued and rarely thought of sex. Jeff's desire for sex occasionally offended his wife, who felt then that he would rather have sex than talk with her. Sometimes when Jeff's wife complied with his requests for sex, she resented him.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (APA, 2000, DSM-IV-TR, p. 356)	At those times Jeff would think a lot about dying and
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	the sense of relief it might bring from the cycle of misery he felt he was in. He never did anything about it though.
		Paragraph 5
MDD criterion	Psychomotor agitation or	Several of Jeff's colleagues had

#5	retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	commented to him in the last couple of weeks that he didn't look his usual brisk self, and that he looked slowed down
MDD criterion #1	Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	and depressed.
MDD criterion #C	Clinically significant distress or impairment in social, occupational, or other areas of functioning because of the depressed mood and/or loss of interest or pleasure (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	The Chief of Staff had called Jeff into his office and indicated that perhaps Jeff should seek counselling from the hospital EAP, and maybe take some time off work after completing his backlog of incomplete patient charts.

Case 2 – Sophie.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of anger possible indicate unresolved trauma work or BPD.	Sophie tells you she has come to see you because she has lost her job recently and is experiencing intense daily anger
MDD criterion #1	Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful) (APA, 2000, DSM-IV-TR, p. 356)	and sadness about this and

	Suggestions of adjustment disorder.	is having difficulty letting it go and
MDD criterion #C	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000, DSM-IV-TR, p. 356)	moving on to search for other work.
		Her executive recruiter told her to get some help with her anger.
		Paragraph 2
		A single executive in her mid-30s, Sophie would say with a smile that her Achilles' heel was her "weakness for good-looking men". When an attractive man indicated to Sophie that he was interested in her sexually, she found herself unable to resist, or more accurately, she found herself unable to want to resist.
		It felt similar to when her swim coach used to flirt with her when she was 13.
		Paragraph 3
		When Sophie discovered online chat groups she suddenly had access to all sorts of men online who seemed to be interested in being sexual with her.
MDD criterion #2	Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day as indicated by either subjective account or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Her friends said it was the only time they saw her show any interest in anything these days given how bored she had been saying she was with everything in her life.
		She began emailing back and forth with several men whom she had never met before but had encountered on the Internet chat

		groups.
		It escalated.
		Paragraph 4
		Over a few weeks she began spending 4-5 hours during the workday checking and responding to her email. Soon she and various men online began to instant message (IM) each other.
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	In this way they became constantly available to each other online throughout the workday.
		She went to her office earlier and stayed at work later so she could stay online later. Then it became weekends too.
OCD criterion #A1 (compulsions)	Feeling driven to perform repetitive behaviors or mental acts in response to an obsession, or according to rules that must be applied rigidly (APA, 2000, DSM-IV-TR, p. 462)	In some ways she felt she had to be tapped into what was happening online in these chat groups at all times,
OCD criterion #A2 (compulsions)	Behaviors or mental acts described in item #24 are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connect in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	otherwise she felt upset and anxious.
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than	When she started losing lots of weight very quickly she reasoned it was because she had been

	5% of body weight in a month), or decrease or increase in appetite nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	working so hard.
MDD criterion #5	Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (APA, 2000, DSM-IV-TR, p. 356)	Her friend told her she seemed restless and fidgety all the time now,
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	and she barely slept.
		Instead she would stay up all night composing emails in her head or fantasizing about what might happen if she met any of the online men in person.
MDD criterion #6	Fatigue or loss of energy nearly every day (APA, 2000, DSM-IV-TR, p. 356)	As a result Sophie felt exhausted almost every day.
		Paragraph 5
		When some of the men she was communicating with online started asking to meet with her, Sophie agreed.
		She began meeting with the men over her lunch hour. Meetings in coffee shops became meetings in her apartment and rapidly progressed from flirtations to sex.
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from	At first Sophie felt guilty about having sex with men she hardly knew at all but she brushed these feelings aside telling herself she was a modern woman.

	previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Sophie's fiancé ended their engagement after she repeatedly broke promises to him that she would stop sleeping with other men.
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional, nearly every day, not merely self-reproach or guilt about being sick (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	After the breakup Sophie felt worthless and terribly guilty for months, but this did not stop her from continuing to meet with the men from online.
		Paragraph 6
CSA criterion #5	A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When Sophie began to use her apartment in the city for midday sexual liaisons, her lunch breaks stretched longer and longer.
CSA criterion #6	Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Her formerly superior work performance began to slacken and she did not receive an expected promotion.
MDD criterion #8	Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous	At work, Sophie had a hard time thinking or concentrating on the tasks in front of her.

	functioning) (APA, 2000, DSM-IV-TR, p. 356)	
OCD criteria #A1 (obsessions) & #A2 (obsessions)	(A1) Obsessions as defined by - recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress, (A2) The thoughts, impulses or images are not simply excessive worries about real-life problems (APA, 2000, DSM-IV-TR, p. 462)	She was frequently bothered by intruding graphic sexual images
OCD criterion #A4 (obsessions)	The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion) (APA, 2000, DSM-IV-TR, p. 462)	from her online chats,
OCD criterion #A3 (obsessions)	Obsessions as defined by - the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action (APA, 2000, DSM-IV-TR, p. 462)	which she would then try to ignore.
		Sophie's boss warned her that she could lose her job if she was unable to keep business and personal separate in her life.
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	Sophie resolved that she would turn over a new leaf and for six weeks she kept her sexual behaviour in check, disconnected her internet access at work and stopped visiting the online chat groups.
		Paragraph 7
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online	Then, when she was working late one night and had just finished a big project, she noticed that her

	sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	neck and back were tight, and told herself she would just unwind a little with a quick visit to the online chat group.
OCD criterion #B	Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the course of his/her disorder (APA, 2000, DSM-IV-TR, p. 462)	As she logged in, in the back of her mind, a tiny thought that her need to go online felt too strong was quickly quieted.
		Within minutes she was instant messaged by one of the men online for a sexual rendezvous. Since there was no one at the office at this late hour, Sophie justified that it would be alright.
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When a male co-worker walked in on her sexual activities, Sophie knew their might be repercussions, yet she continued to liase with men from the online chat group during her lunch hours.
		At the same time the co-worker who had walked in on Sophie began to pressure her for sexual favours. When she brushed him off, he disclosed to the boss Sophie's after hours office activities. Since this was against company policy, she was fired immediately.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (APA, 2000, DSM-IV-TR, p. 356)	Since being fired Sophie has been having frequent intrusive thoughts about killing herself by driving her car off the road.

Case 3 – Bill.

Diagnostic Criteria Number	Diagnostic Criteria Symptom	Corresponding line/phrase/sentence in Case
		Paragraph 1
	Suggestions of depression with suicidality.	Bill tells you he has come to see you because he was has lost his marriage and is feeling depressed and suicidal.
	Suggestions of adjustment disorder.	His pastor suggested Bill get some support coping with the loss of his marriage and referred Bill to you.
		Paragraph 2
		An electrician in his mid-20s, married for 3 years, Bill had masturbated nearly every night before going to sleep since his middle teens when he first discovered online porn pictures and videos.
CSA criterion #7	The psychological problem that is likely to have been caused or exacerbated by online sexual behaviour continues despite knowledge of its consequences. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	When he quit using alcohol and other drugs in his early 20s, his sexual fantasies and urges became more frequent and more intense.
MDD criterion #1	Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	At about the same time his wife and his sister started commenting that Bill appeared to be
MDD criterion #2	Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by	depressed and uninterested in the things he used to do, moping about the house when home and not seeing his friends anymore.

	others) (APA, 2000, DSM-IV-TR, p. 356)	
		Paragraph 3
MDD criterion #4	Insomnia or hypersomnia nearly every day (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	He began to experience strong urges to masturbate in the morning, usually after having had a hard time getting to sleep, which was a frequent occurance.
OCD criterion #A2 (compulsions)	The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife.
CSA criteria #2a & 2b	(2a) Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour, (2b) The same (or closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife.
MDD criterion #5	Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	During these times, his wife and coworkers would notice and tell Bill to relax and that he was making them nervous because he was so jumpy.

CSA criterion #3	The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Consequently, he started to view online porn and masturbate before work, even though he would sometimes arrive late,
MDD criterion #5	Psychomotor agitation or retardation nearly every day observable by others, not merely subjective feelings of restlessness or being slowed down (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	dazed and zoned out as a result.
		Paragraph 4
CSA criteria #1a & 1b	(1a) a need for markedly increased amount of intensity of the online sexual behaviour to achieve the desired effect, (1b) markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours.
OCD criterion #C	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships (APA, 2000, DSM-IV-TR, p. 462)	Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours.
OCD criterion #A2	The behaviours or mental acts are aimed at preventing or reducing distress or	Bill would search for hours for sexual images, sorting them into meticulous categories and folders

(compulsions)	preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive (APA, 2000, DSM-IV-TR, p. 462)	and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his private locker at work. As he searched he would become more and more tense but the organizing of the images seemed to soothe him. When Bill would find the "perfect" image he would stop searching and masturbate to it.
OCD criterion #A1 (compulsions)	Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (APA, 2000, DSM-IV-TR, p. 462)	Bill would search for hours for sexual images, sorting them into meticulous categories and folders and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his private locker at work. As he searched he would become more and more tense but the organizing of the images seemed to soothe him. When Bill would find the "perfect" image he would stop searching and masturbate to it.
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (APA, 2000, DSM-IV-TR, p. 356)	The process so consumed him that he lost interest in food.
		Paragraph 5
MDD criterion #3	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (APA, 2000, DSM-IV-TR, p. 356)	No longer sufficiently excited by viewing porn online, Bill began to purchase online "live" strippers and "live" streaming videos of sexual acts.
OCD criteria # A1 (obsessions) & A2 (obsessions)	(A1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety	He couldn't stop thinking about porn and what he'd seen online even when he so desperately wanted to pay attention to his wife.

	or distress, (A2) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress (APA, 2000, DSM-IV-TR, p. 462)	
CSA criterion #6	Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	His wife caught him watching "live" porn at home one day and told him if he didn't stop she would leave him.
MDD criterion #8	Diminished ability to think or concentrate, or indecisiveness, nearly every day, either by subjective account or as observed by others (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	He also received a second warning about tardiness and inattentiveness at work.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	He felt disgusted with himself and started to have recurring thoughts of killing himself and escaping all the problems;
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	but each time he tried to stop going online to surf for sex, he would fail.
		Paragraph 6

CSA criterion #5	A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, "Cybersex: The dark side of the force", p. 115)	Sexual images and fantasies accompanied by arousal would intrude into his consciousness throughout the day,
OCD criteria #A1 (obsessions) & A2 (obsessions)	(A1) Recurrent and persistent thoughts, impulses or images that are experienced, at some time during disturbance, as intrusive and inappropriate and that cause marked anxiety or distress, (A2) The recurrent and persistent thoughts, impulses, or images as described in item #20 are not simply excessive worries about real life problems (APA, 2000, DSM-IV-TR, p. 462)	whether he wanted them to or not, and he would feel as though he was going to explode.
MDD criterion #6	Fatigue or loss of energy nearly every day (APA, 2000, DSM-IV-TR, p. 356)	At night Bill was having difficulty sleeping, feeling jittery and unable to relax with sexual images swirling through his head, resulting in exhaustion during the day.
OCD criterion #A3 (obsessions)	Attempts made to ignore or suppress such thoughts, impulses, or images as described in item #20, or to neutralize them with some other thought or action (APA, 2000, DSM-IV-TR, p. 462)	The only thing that would make them go away was logging back online to search for and look at more sex sites.
OCD criteria #A4 (obsessions) & B	(A4) Recognizes that the obsessional thoughts, impulses, or images as described in item #20 are the product of his/her own mind (not imposed from without as in thought insertion), (B) Recognizes that the obsessions or compulsions are excessive or unreasonable at some point during the	He occasionally thought to himself that this was crazy and that he was stuck in a never-ending loop.

	course of his/her disorder (APA, 2000, DSM-IV-TR, p. 462)	
		Paragraph 7
CSA criterion #4	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour. (Goodman, A. (1998) as cited in Orzack & Ross, 2000, “Cybersex: The dark side of the force”, p. 115)	When his wife became pregnant, he deleted his collection of online pornography and his list of online favorites and resolved to quit masturbating.
		Within a few months, though, he again lost control of his online surfing and masturbation and the marriage soon fell apart.
		Before long he had "maxed-out" his credit cards.
MDD criterion #9	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (during the same 2-week period and representing a change from previous functioning) (APA, 2000, DSM-IV-TR, p. 356)	Socially isolated, deeply in debt, suicidal,
MDD criterion #C	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000, DSM-IV-TR, p. 356)	and about to lose his job,
MDD criterion #7	Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (APA, 2000, DSM-IV-TR, p. 356)	Bill felt powerless and worthless.

Appendix P

CVSI-V1 Question 1 Items Numbers Corresponding with CSA, MDD, and OCD Diagnostic Criteria

CSA Diagnostic criteria presented in each case of the CVSI-V1 and corresponding Question 1 Items

Cybersex Addiction (CSA) Diagnostic Criteria (see Appendix D) A maladaptive pattern of online sexual behaviour, leading to clinically significant impairment or distress, as manifested by three (or more) of the following and occurring at any time in the same 12-month period		**Corresponding CVSI-V1 question items**	**Case 1 - Sophie**	**Case 2 - Bill**	**Case 3 - Jeff**
CSA 1 (a)	Tolerance, as defined by - a need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect	**1**		**x**	
CSA 1 (b).	Tolerance, as defined by - markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity	**4**		**x**	
CSA 2 (a).	Withdrawal, as manifested by - characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behaviour	**7**		**x**	
CSA 2 (b).	Withdrawal, as manifested by - the same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms	**10**		**x**	
CSA 3.	The online sexual behaviour is often engaged in over a longer period, in greater quantity or at a higher level of intensity than was intended	**13**		**x**	
CSA 4.	There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour	**16**	**x**	**x**	
CSA 5.	A great deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour or to recover from its effects	**19**	**x**	**x**	**x**
CSA 6.	Important social, occupational or recreational activities are given up or reduced because of the online sexual behaviour	**22**	**x**	**x**	
CSA 7.	The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences	**25**	**x**	**x**	**x**

MDD Diagnostic criteria presented in each case of the CVSI-V1 and corresponding Question 1 Items

Major Depressive Disorder (MDD) Diagnostic Criteria (see Appendix I) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change form previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.		**Corresponding CVSI-V1 question items**	**Case 1 - Sophie**	**Case 2 - Bill**	**Case 3 - Jeff**
A(a-1).	depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)	**2**		**x**	**x**
A(a-2).	markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)	**5**	**x**		
A(a-3).	significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day	**8**	**x**		**x**
A(a-4).	insomnia or hypersomnia nearly every day	**11**	**x**	**x**	**x**
A(a-5).	psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)	**14**		**x**	**x**
A(a-6).	fatigue or loss of energy nearly every day	**17**			**x**
A(a-7).	feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)	**20**	**x**		
A(a-8).	diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)	**23**	**x**	**x**	
A(a-9).	recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide	**26**		**x**	
A(a-c).	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning	**27**			**x**

OCD Diagnostic criteria presented in each case of the CVSI-V1 and corresponding Question 1 Items

Obsessive Compulsive Disorder (OCD) Diagnostic Criteria (see Appendix E) Either obsessions or compulsions: Obsessions as defined by A (Obsessions) (1), (2), (3), and (4). Compulsions as defined by A (Compulsions) (1) and (2).		**Corresponding CVSI-V1 question items**	**Case 1 - Sophie**	**Case 2 - Bill**	**Case 3 - Jeff**
A (Obsessions) – 1.	Obsessions as defined by - recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress	**3**		**X**	**x**
A (Obsessions) – 2.	Obsessions as defined by - the thoughts, impulses, or images are not simply excessive worries about real-life problems	**6**		**X**	
A (Obsessions) – 3.	Obsessions as defined by - the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action	**9**		**x**	**x**
A (Obsessions) – 4.	Obsessions as defined by - the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)	**12**		**x**	**x**
A (Compulsions) – 1.	Compulsions as defined by - repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly	**15**	**x**	**x**	
A (Compulsions) – 2.	Compulsions as defined by - the behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive	**18**	**x**		
B.	At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable	**21**	**x**	**x**	
C.	The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships	**24**	**x**	**x**	

Appendix Q

Online Demographic Survey - Pilot (Phase I)

Questionnaire #1

1.Ph.D. student

- ○ No
- ○ Yes

2.a. Enrolled in either a Counselling or Clinical Psychology program

- ○ No
- ○ Yes

b. If you answered 'yes' to 2.a. above, identify the type of psychology program in which you are enrolled

- ○ Clinical Psychology
- ○ Counselling Psychology

3. Highest level of education completed (Please select only one)

- ○ Undergraduate (Bachelor)
- ○ Masters
- ○ Ph.D.
- ○ Psy.D.

4. Population of Specialization (please select all that apply)

- ☐ Adults
- ☐ Couples
- ☐ Families
- ☐ Children
- ☐ Adolescents
- ☐ None at this time

Other (please specify)

5. If working, current workplace setting (please select all that apply)

- [ ] Hospital; Inpatient
- [ ] Hospital; Outpatient
- [ ] Correctional Facility
- [ ] Private Practice
- [ ] Non-profit Agency
- [ ] School
- [ ] Community Service Centre
- [ ] Not currently working
- [ ] Non-psychology related

Other (please specify)

6. Age in years (Please DO NOT provide your birthdate)

7. Gender

- ○ Male
- ○ Female
- ○ Other (please specify)

8. Ethnicity (please select the ONE below that you feel best describes your ethnicity)

- ○ Canadian
- ○ American
- ○ Aboriginal
- ○ British Isles
- ○ French Acadian
- ○ French European
- ○ Northern European
- ○ Scandinavian
- ○ Southern European
- ○ Eastern European
- ○ Baltic
- ○ Czech and Slovak
- ○ Western European
- ○ Other European
- ○ African
- ○ Middle-Eastern/ Arab
- ○ Maghrebi
- ○ South Asian
- ○ East and Southeast Asian
- ○ West Asian
- ○ Oceania
- ○ Pacific Islands
- ○ Latin, Central & South American
- ○ Bi-racial
- ○ Multi-racial
- ○ Other (please specify)

9. Number of years lived in Canada

10. Current relationship status (please check only one)

- Married
- Common-Law
- Casually Dating
- In a Monogamous Relationship
- Other (please specify)
- Separated
- Widowed
- Divorced
- Single

11. Sexual orientation

	1 (Heterosexual)	2	3	4	5	6	7 (Homosexual)
sexual orientation							

12. Comfort with using a COMPUTER

	1 (Extremely Uncomfortable)	2	3	4	5 (Extremely Comfortable)
Comfort level					

13. Comfort with using the INTERNET

	1 (Extremely Uncomfortable)	2	3	4	5 (Extremely Comfortable)
Comfort level					

14. Number of hours per week you use the COMPUTER for:
(it may help to use the last 2 weeks as a reference)

	0	1 - 5	6 - 10	11 - 20	21 – 30	31 – 40	41 – 50	more than 50
Personal purposes								
Professional purposes								

15. Number of hours per week you use the INTERNET for:
(it may help to use the last 2 weeks as a reference)

	0	1 - 5	6 - 10	11 - 20	21 – 30	31 – 40	41 – 50	more than 50
Personal purposes								
Professional purposes								

16. Purposes for which you generally use the COMPUTER (please check all that apply)

- ☐ Creating or editing documents
- ☐ Creating or editing spreadsheets
- ☐ Emailing
- ☐ Calendar management
- ☐ Arranging meetings
- ☐ Creating/managing To-Do lists
- ☐ Creating presentations
- ☐ Photo storage
- ☐ Photo editing
- ☐ Image creating
- ☐ Image editing
- ☐ Reading journal articles
- ☐ Data analysis
- ☐ Video conferencing
- ☐ Searching the Internet
- ☐ Computer games
- ☐ Reading CD-ROMs
- ☐ Playing DVDs
- ☐ Organizing files/folders
- ☐ Video storage
- ☐ Video editing
- ☐ Website design
- ☐ Software programming
- ☐ N/A: I have never used a computer
- ☐ Other (please specify)

17. Purposes for which you generally use the INTERNET(please check all that apply)

- ☐ Entertainment
- ☐ Online computer games
- ☐ Emailing
- ☐ Calendar management
- ☐ Shopping
- ☐ Professional work
- ☐ Travel planning and/or booking
- ☐ Photo storage
- ☐ Photo editing
- ☐ Image editing
- ☐ Researching journal articles
- ☐ Downloading journal articles
- ☐ Web conferencing
- ☐ General Browsing
- ☐ Chat sites
- ☐ Interactive on-line games
- ☐ Searching for people/places
- ☐ Blogging
- ☐ Photo sharing
- ☐ Video editing
- ☐ Website creation (for self/others)
- ☐ MSN
- ☐ ICQ
- ☐ Skype
- ☐ Twitter
- ☐ Facebook
- ☐ My Space
- ☐ Instant Messaging (IM)
- ☐ Banking
- ☐ N/A: I have never used the Internet
- ☐ Other (please specify)

18. Amount of training you have received in each of these areas of psychology (using the below scale place the number that represents your amount of training received in the box next to each of the areas indicated)

(No Training At All) 0 ----------> 6 (Extensive Training)

	Amount of Trainining Received		
Personality Disorders		Cognitive-Behavior Therapy	
Substance Abuse		Aviation Psychology	
Disaster Relief Psychology		Mood Disorders	
Drug Addiction		Emotion-Regulation	
Process Addictions		Dance Therapy	
Schizophrenia		Music Therapy	
Anxiety Disorders		Psychodrama	
Forensic Psychology		Sex/Cybersex Addiction	
Borderline Personality Disorder		Veteran Affairs	
Dialectical-Behaviour Therapy		Industrial/Organizational Psychology	
Narrative Therapy		Positive Psychology	
Eating Disorders		Psychotic Disorders	
Sleep Disorders		International Psychology	
Bipolar Disorders		Environmental/ Conservation Psychology	
Pathological Gambling			
Internet Addiction			
Alcohol Addiction			
Post-Traumatic Stress Disorder			
User-Interface Psychology			
Military Psychology			
Geriatric Psychology (Geropsychology)			
Obsessive Compulsive Disorders			
Attachment Disorders			

Other (please specify each additional area on a seperate line and indicate for each area added the amount of training in brackets using the above 0-6 scale)

Appendix R

Sexual Opinion Survey - Revised (SOS-R) and Scoring Protocol

Sexual Opinion Survey – Revised (SOS-R)

(Fisher, White, et al., 1988)

Please respond to each item as honestly as you can by placing a check mark directly on the line that best describes your feelings. There are no right or wrong answers, and your answers will be completely confidential.

1. I think it would be very entertaining to look at erotica (sexually explicit books, movies, etc.).

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

2. Erotica (sexually explicit books, movies, etc.) is obviously filthy and people should not try to describe it as anything else.

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

3. Swimming in the nude with a member of the opposite sex would be an exciting experience.

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

4. Masturbation can be an exciting experience.

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

5. If I found out that a close friend of mine was a homosexual, it would annoy me.

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

6. If people thought I was interested in oral sex, I would be embarrassed.

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

7. Engaging in group sex is an entertaining idea.

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

8. I personally find that thinking about engaging in sexual intercourse is arousing.

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

9. Seeing an erotic (sexually explicit) movie would be sexually arousing to me.

   I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

10. Thoughts that I may have homosexual tendencies would not worry me at all.

    I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

11. The idea of my being physically attracted to members of the same sex is not depressing.

    I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

12. Almost all erotic (sexually explicit) material is nauseating.

    I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

13. It would be emotionally upsetting to me to see someone exposing themselves publicly.

    I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

14. Watching a stripper of the opposite sex would not be very exciting.

    I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

15. I would not enjoy seeing an erotic (sexually explicit) movie.

    I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

16. When I think about seeing pictures showing someone of the same sex as myself masturbating, it nauseates me.

    I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

17. The thought of engaging in unusual sex practices is highly arousing.

I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

18. Manipulating my genitals would probably be an arousing experience.

I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

19. I do not enjoy daydreaming about sexual matters.

I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

20. I am not curious about explicit erotica (sexually explicit books, movies, etc.).

I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

21. The thought of having long-term sexual relations with more than one sex partner is not disgusting to me.

I strongly agree: ____ : ____ : ____: ____ : ____ : ____ : ____ : I strongly disagree

SOS-R Scoring Protocol (Fisher, White, et al., 1988, P. 127):

1. Score responses from 1 = I strongly agree to 7 = I strongly disagree

2. Add scores from items 2, 5, 6, 12, 13, 14, 15, 16, 19, and 20

3. Subtract from this total the sum of items 1, 3, 4, 7, 8, 9, 10, 11, 17, 18, and 21

4. Add 67 to this quantity

Scores range from 0 (most erotophobic) to 126 (most erotophilic)

Appendix S

Modified Sexual Opinion Survey – Revised (SOS-R-M) and Scoring Protocol

Modified Sexual Opinion Survey – Revised (SOS-R-M)

(Adapted with permission from Fisher, White, et al., 1988)

Instructions: Please respond to each item as honestly as you can by placing a check mark directly on the line that best describes your feelings.

There are no right or wrong answers.

1. I think it would be very entertaining to look at erotica (sexually explicit Internet sites, chat rooms, books, magazines, movies, etc.).

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

2. Erotica (sexually explicit Internet sites, chat rooms, books, magazines, movies, etc.) is obviously filthy and people should not try to describe it as anything else.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

3. Swimming in the nude with a member of the opposite sex would be an exciting experience.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

4. Masturbation can be an exciting experience.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

5. If I found out that a close friend of mine was a homosexual, it would annoy me.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

6. If people thought I was interested in oral sex, I would be embarrassed.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

7. Engaging in group sex is an entertaining idea.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

8. I personally find that thinking about engaging in sexual intercourse is arousing.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

9. Seeing an erotic (sexually explicit) movie/ on-line video/ Internet site/ on-line Chat/ magazine/ book would be sexually arousing to me.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

10. Thoughts that I may have homosexual tendencies would not worry me at all.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

11. The idea of my being physically attracted to members of the same sex is not depressing.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

12. Almost all erotic (sexually explicit) material is nauseating.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

13. It would be emotionally upsetting to me to see someone exposing themselves publicly.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

14. Watching a stripper of the opposite sex would not be very exciting.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

15. I would not enjoy seeing an erotic (sexually explicit) movie/ on-line video/ Internet site/ on-line Chat/ magazine/ book.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

16. When I think about seeing pictures showing someone of the same sex as myself masturbating, it nauseates me.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

17. The thought of engaging in unusual sex practices is highly arousing.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

18. Manipulating my genitals would probably be an arousing experience.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

19. I do not enjoy daydreaming about sexual matters.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

20. I am not curious about explicit erotica (sexually explicit Internet sites, chat rooms, books, magazines, movies, etc.).

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

21. The thought of having long-term sexual relations with more than one sex partner is not disgusting to me.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

SOS-R-M Scoring Protocol (adapted with permission from Fisher, White, et al., 1988, P. 127):

1. Score responses from 1 = I strongly agree to 7 = I strongly disagree

2. Add scores from items 2, 5, 6, 12, 13, 14, 15, 16, 19, and 20

3. Subtract from this total the sum of items 1, 3, 4, 7, 8, 9, 10, 11, 17, 18, and 21

4. Add 67 to this quantity

Scores range from 0 (most erotophobic) to 126 (most erotophilic)

Appendix T

Online Consent Form - Pilot (Phase I)

1. Informed Consent Form

STUDY ABOUT THE ROLE OF THERAPISTS' CHARACTERISTICS IN THEIR PERCEPTIONS OF CLIENTS' PRESENTING PROBLEMS

Principal Investigator: Easter Yassa, M.A.

Purpose of the research: fulfillment of dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta, Edmonton, Alberta.

CONSENT FORM

I ask that you read this form before agreeing to participate in this study.

Description of the research

You are invited to participate in a study to examine if there is a relationship between therapists' characteristics and their perceptions of the presenting problems of their clients. There are no right or wrong answers on the following surveys and this is not a test.

You are invited to visit click here starting on July 1, 2010 for a full explanation of this study. This website will be available for a period of one month after its posting.

What will my participation involve?

If you decide to participate in this research, consent will be given upon your commencement of the study. You will be asked to complete 3 questionnaires, which will include;

- personal and professional demographic questions
- questions about your sexual attitudes
- 3 written client vignettes and subsequent questions about what you think the issue is for the client represented in the vignette

Your participation will last approximately 30 – 45 minutes. If you have already received a mailed package regarding this study, you can complete these questionnaires by paper and then return them in the stamped return-addressed envelope that was in the package. If you have not received this mailed package or, if you prefer, an online version of the questionnaires is also available for your convenience by clicking continue at the bottom of this consent form. If you complete the surveys online you must do so in one sitting as exiting the online survey will cause all your data to be lost.

How will my confidentiality be protected?

All the data enclosed in this study will be anonymous and coded and will not be identified with you personally in any way. The anonymous ID which you will be prompted to create is used only to keep your surveys together without identifying who you are. All surveys, when returned will be kept secure and confidential even though they will contain no identifying information.

Are there any risks to me?

I don't anticipate any risks to you from your participation in this research, however, some of the questions are of a sexual nature and some people may feel some mild discomfort in reading and responding to them. You are of course free to choose not to participate in this research at no consequence to yourself.

Are there any benefits to me?

The benefits of participation, however, are significant and include the knowledge that you have contributed something valuable to the knowledge base of your profession and have assisted indirectly in helping other therapists (including graduate students and seasoned professionals) learn about their role in the therapeutic assessment process.

What are my rights as a participant?

As a participant you have several rights you should be aware of. You have the right to;

- Not participate

- Privacy, anonymity and confidentiality

- Safeguards for the security of data and when appropriate (after a minimum of 5 years) the appropriate methods for the destruction of data that ensures your continued privacy and confidentiality

- Disclosure regarding the presence of any apparent or actual conflict of interest on the part of the researcher

- A copy of the report of the research findings when it is completed by advising the researcher via mail, email or telephone.

If I want to withdraw my participation after I have submitted the surveys, can I?

Unfortunately, no. Once you submit your completed surveys withdrawal of your specific data will not be possible given that the surveys are anonymous and no information will be kept linking your anonymous survey to your identifying information.

What do you plan to do with the data?

On completion of this study I intend to publish the findings making them accessible for all who are interested.

Who do I contact if I have any questions?

If you have any questions about your rights as a research subject, you should contact the principal investigator, Easter Yassa, at eyassa@ualberta.ca or via mail at: Easter Yassa, Department of Educational Psychology, 6-102 Education North, University of Alberta, Edmonton, AB, T6G 2G5. You may also contact the University of Alberta, Department of Educational Psychology at 780- 492-5245 if you have any questions or comments regarding the research.

Remember your participation is completely voluntary. If you begin filling out the survey(s) and change your mind at any time, you may end your participation without penalty by either not returning the paper surveys or, if choosing to complete them online, simply closing the browser window.

Thank you.

Sincerely,

Easter Yassa, MA, Ph.D. Student, Counselling Psychology
Department of Education, University of Alberta
Tel: 780- 504-3363; Email: eyassa@ualberta.ca

Please Note: The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at 780-492-3751.

By clicking on the continue button below you are agreeing to the following;

• I am at least 18 years of age and have read and understood the above information, and

• I consent to voluntarily participate in this study

• In understand that once I submit my completed surveys I will not be able to withdraw my data as the surveys are anonymous and cannot be linked with my identifying information

CONTINUE

EXIT

Appendix U

Results of CVSI-V1 Question 2 - Pilot (Phase I)

CASE 1: SOPHIE							
N = 18							
Likert Rating Label	Primary problem in need of therapeutic attention	Primary problem in need of therapeutic attention (grouped)	2	3	4	Most peripheral problem in need of therapeutic attention	Problem not in need of therapeutic attention
Likert Rating	1 (%)	1 (%) group	2 (%)	3 (%)	4 (%)	5 (%)	0 (%)
SA	5 (27.8%)	10 (55.55%)	2 (11.1%)	3 (16.7%)	0 (0%)	1 (5.6%)	7 (38.9%)
CSA	5 (27.8%)		4 (22.2%)	0 (0%)	1 (5.6%)	1 (5.6%)	7 (38.9%)
MDD-SE	1 (5.6%)	5 (27.8%)	3 (16.7%)	1 (5.6%)	1 (5.6%)	0 (0%)	12 (66.7%)
MDD-RE	4 (22.2%)		0 (0%)	0 (0%)	0 (0%)	0 (0%)	14 (77.8%)
OCD	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (16.7%)	1 (5.6%)	14 (77.8%)
Other	3 (16.66%)	3 (16.66%)	9 (50%)	14 (77.8%)*	13 (72.22%)**	15 (83.33%)	
Other Includes:	PTSD (1)		Substance Induced Mood Disorder (manic features) (1)	Substance Induced Anxiety Disorder (with obsessive-compulsive symptoms) (2)	Substance Induced Mood Disorder (manic features) (1)	Delirium, Dementia, or other cognitive disorder (2)	
	Adjustment Disorder (1)		Substance Induced Anxiety Disorder (with obsessive-compulsive symptoms) (1)	Depressive Disorder NOS (2)	Dysthymic Disorder (1)	Substance Induced Anxiety Disorder (with obsessive-compulsive symptoms) (1)	
	Relational Problems (1)		Dysthymic Disorder (1)	Bipolar I Disorder (1*)	Hypoactive Sexual Desire Disorder (2)	Dysthymic Disorder (3)	
			PTSD (2)	PTSD (3)	Dissociative Disorder (1)	Depressive Disorder (1)	
			Sexual Disorder NOS (1)	Hypoactive Sexual Desire Disorder (1)	Sexual Disorder NOS (3)	PTSD (1)	
			Impulse Control Disorder NOS (2)	Sexual Disorder NOS (1)	Impulse Control Disorder NOS (3)	Impulse Control Disorder NOS (3)	
			Adjustment Disorder (disturbance of conduct) (1)	Impulse Control Disorder NOS (3*)	Relational Problems (1)	Relational Problems (2)	
				Relational Problems (2)		Religious or Spiritual Problem (1)	
						Phase of Life Problem (1)	
*	participant #918571799 rated two problems in need of therapeutic attention as '3' and neglected to rate one as '4'						
**	participant #918571799 rated two problems in need of therapeutic attention as '3' and neglected to rate one as '4'						

CASE 2: BILL							
N = 14							
Likert Rating Label	Primary problem in need of therapeutic attention	Primary problem in need of therapeutic attention (grouped)	2	3	4	Most peripheral problem in need of therapeutic attention	Problem not in need of therapeutic attention
Likert Rating	1 (%)	1 (%) group	2 (%)	3 (%)	4 (%)	5 (%)	0 (%)
SA	2 (14.3%)	8 (57.1%)	3 (21.4%)	0 (0%)	0 (0%)	0 (0%)	9 (64.3%)
CSA	6 (42.9%)		3 (21.4%)	1 (7.1%)	0 (0%)	0 (0%)	4 (28.6%)
MDD-SE	0 (0%)	4 (28.6%)	3 (21.4%)	0 (0%)	0 (0%)	0 (0%)	11 (78.6%)
MDD-RE	4 (28.6%)		0 (0%)	3 (21.4%)	1 (7.1%)	1 (7.1%)	5 (35.7)
OCD	2 (14.3%)	2 (14.3%)	1 (7.1%)	0 (0%)	3 (21.4%)	1 (7.1%)	7 (50%)
Other	0 (0%)	0 (0%)	4 (28.6%)	10 (71.4%)	10 (71.4%)	12 (85.7%)	
Other Includes:			Dysthymic Disorder (1)	Substance Induced Anxiety Disorder (with obsessive-compulsive symptoms) (4)	Substance Induced Mood Disorder (manic features) (1)	Delerium, Dementia, or other cognitive disorder (1)	
			Depressive Disorder NOS (1)	Delusional Disorder (erotomania) (1)	Depressive Disorder NOS (1)	Substance Induced Anxiety Disorder (with obsessive-compulsive symptoms) (1)	
			Impulse Control Disorder NOS (1)	Sexual Disorder NOS (1)	Impulse Control Disorder NOS (3)	Dysthymic Disorder (1)	
			Relational Problems (1)	Impulse Control Disorder NOS (3)	Borderline Personality Disorder (1)	Hypoactive Sexual Desire Disorder (1)	
				Relational Problems (1)	Relational Problems (4)	Dissociative Disorder (1)	
						Sexual Disorder NOS (1)	
						Impulse Control Disorder NOS (1)	
						Adjustment Disorder (disturbance of conduct) (1)	
						Relational Problems (2)	
						Phase of Life Problem (2)	

CASE 3: JEFF								
				N = 12				
Likert Rating Label	Primary problem in need of therapeutic attention	Primary problem in need of therapeutic attention (grouped)	2	3	4	Most peripheral problem in need of therapeutic attention	Problemnot in need of therapeutic attention	
Likert Rating	1 (%)	1 (%) group	2 (%)	3 (%)	4 (%)	5 (%)	0 (%)	
SA	4 (33.3%)	4 (33.3%)	0 (0%)	2 (16.7%)	4 (33.3%)	0 (0%)	2 (16.7%)	
CSA	0 (0%)		0 (0%)	0 (0%)	0 (0%)	2 (16.7%)	10 (83.3%)	
MDD-SE	2 (16.7%)	2 (16.7%)	1 (8.3%)	1 (8.3%)	0 (0%)	0 (0%)	8 (66.7%)	
MDD-RE	0 (0%)		3 (25%)	1 (8.3%)	2 (16.7%)	0 (0%)	6 (50%)	
OCD	1 (8.3%)	1 (8.3%)	0 (0%)	2 (16.7%)	2 (16.7%)	1 (8.3%)	6 (50%)	
Other	5 (41.66%)	5 (41.66%)	8 (66.7%)	6 (50%)	4 (33.3%)	9 (75%)		
Other Includes:	Depressive Disorder NOS (1)		Dysthymic Disorder (1)	Depressive Disorder NOS (1)	Sexual Disorder NOS (2)	Dysthymic Disorder		
	Hypoactive Sexual Desire Disorder (1)		Depressive Disorder NOS (1)	Sexual Disorder NOS (1)	Impulse Control Disorder NOS (1)	Sexual Disorder NOS (2)		
	Relational Problems (3)		Hypoactive Sexual Desire Disorder (1)	Relational Problems (4)	Adjustment Disorder (disturbance of conduct) (1)	Impulse Control Disorder NOS (2)		
			Sexual Disorder NOS (1)		Borderline Personality Disorder (1)	Relational Problems		
			Impulse Control Disorder NOS (1)			Phase of Life Problem (2)		
			Relational Problems (3)					

Phase I (Pilot) - Results of Chi-Square Goodness of Fit for CVSI-V1 Question 2			
	Sophie	Bill	Jeff
Primary diagnosis identified as CSA only (vs. Other)	χ^2 (1, n = 18) = 3.556, p = 0.059*	χ^2 (1, n = 14) = 0.286, p = 0.593	p = 0.00‡*#
Primary diagnosis identified as either CSA or SA (vs. Neither CSA nor SA)	χ^2 (1, n = 18) = 0.222, p = 0.637	χ^2 (1, n = 14) = 0.286, p = 0.593	χ^2 (1, n = 12) = 1.333, p = 0.248
Primary diagnosis identified as either MDD-Single Episode or MDD-Recurrent Episode (vs. Neither MDD-Single Episode nor MDD-Recurrent Episode)	χ^2 (1, n = 18) = 3.556, p = 0.059*#	χ^2 (1, n = 14) = 2.571, p = 0.109	χ^2 (1, n = 12) = 5.333, p = 0.021*
Primary diagnosis identified as OCD (vs. Other)	p = 0.00‡*	χ^2 (1, n = 14) = 7.143, p = 0.008*#	χ^2 (1, n = 12) = 8.333, p = 0.004*#

‡	Chi-Square Goodness of Fit could not be conducted because one there were no cases in one of the two groups so Binomial Test with 50% probability conducted instead to determine significance.
*	$p \leq .10$
#	participants perceived correctly the symptoms and diagnoses built into the indicated cases

Appendix V

CVSI-V2 and CSA Subscale Scoring Protocol

Dear Participant:
Below are 3 fictional client cases. After each case there are 2 sets of questions.
Please read through each case carefully in turn and answer the questions immediately following it.
Thank you.

CASE 1 – JEFF.

Jeff tells you he has come to see you because he is feeling very anxious about the hospital Chief of Staff's recommendation that he take some time off work and is worried about his career. Jeff, a married neurologist in his 40s, feels tired, without energy, and is having difficulty concentrating all the time now. It doesn't seem to matter how much time he sets aside for sleep, he just never sleeps more than 2-3 hours a night. This has been going on for 2 months.

In his marriage, sex was among one of the main sources of tension. Jeff wanted to have sex with his wife every day, sometimes two or three times a day. He thought and fantasized about it obsessively. His wife said he seemed to have lost interest in anything else. He thought about having sex almost constantly, accompanied by feelings of intense nervousness that his wife would turn him down again if he asked. Jeff had grown up Catholic and every time he had a fantasy pop into his head he would mentally run through the Lord's Prayer in hopes that it would stop the sexual thoughts intruding into his head and reduce his urge to have sex. He knew his mind had worked this way since he was a young man. Growing up and even now he often had the feeling that he was struggling with these thoughts more than his other male friends.

When Jeff's wife declined to have sex with him, he felt desperate and feared that she did not love him, that he was not good enough for her, that she was tired of him and was preparing to leave him. Jeff was spending a lot of time feeling intensely guilty nearly every day about his desire for sex. On such occasions, and sometimes to interrupt the almost constant thoughts of sex, he withdrew to his study and immersed himself in work, rechecking patient diagnoses. Sometimes for a few hours a night several times a week he would attempt to get his sexual needs met by reading online erotica and masturbating, but he did not seek sex elsewhere. Sometimes he felt guilty about looking online for sexual release but he didn't know what else to do.

When Jeff wasn't working and thinking about sex he was eating. In fact, he and his wife and colleagues had noticed that he had gained 10-15 lbs in the last month alone. When his wife's inflammatory bowel disease flared up, Jeff cared for her sensitively, and she expressed her appreciation and gratitude. At such times, Jeff felt needed and valued and rarely thought of sex. Jeff's desire for sex occasionally offended his wife, who felt then that he would rather have sex than talk with her. Sometimes when Jeff's wife complied with his requests for sex, she resented him. At those times Jeff would think a lot about dying and the sense of relief it might bring from the cycle of misery he felt he was in. He never did anything about it though.

Several of Jeff's colleagues had commented to him in the last couple of weeks that he didn't look his usual brisk self, and that he looked slowed down and depressed. The Chief of Staff had called Jeff into his office and indicated that perhaps Jeff should seek counselling from the hospital EAP, and maybe take some time off work after completing his backlog of incomplete patient charts.

Feedback regarding above CASE 1 vignette (Jeff):

CASE 1 – QUESTION 1.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Jeff).

A ranking of '1' means that you believe this to be THE PRIMARY PROBLEM in need of therapeutic attention, while a ranking of '5' means that you believe this to be THE MOST PERIPHERAL PROBLEM in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

	Ranking
Delirium, dementia, or other cognitive disorder	
Substance-Induced Mood Disorder (manic features)	
Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)	
Major Depressive Disorder – Single Episode	
Major Depressive Disorder – Recurrent	
Dysthymic Disorder	
Depressive Disorder NOS	
Bipolar I Disorder	
Bipolar II Disorder	
Cyclothymic Disorder	
Obsessive-Compulsive Disorder	
Posttraumatic Stress Disorder	
Hypoactive Sexual Desire Disorder	
Dissociative Disorder	
Delusional Disorder (erotomania)	
Paraphilia	
Paraphilia NOS	
Sex Addiction	
Cybersex Addiction	
Gender Identity Disorder in Adults	

Sexual Disorder NOS	
Impulse-Control Disorder NOS	
Adjustment Disorder (disturbance of conduct)	
Borderline Personality Disorder	
Avoidant Personality Disorder	
Relational Problems	
Religious or Spiritual Problem	
Phase of Life Problem	
Unspecified Mental Disorder (nonpsychotic)	

Feedback regarding the items in QUESTION 1 above for Case 1 (Jeff):

CASE 1 – QUESTION 2.

Instructions: By selecting only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Jeff).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

10. Insomnia or hypersomnia nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

12. Psychomotor agitation or retardation nearly every day observable by others

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

16. Fatigue or loss of energy nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

17. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

18. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

Feedback regarding the items in QUESTION 2 above for Case 1 (Jeff):

CASE 2 - SOPHIE.

Sophie tells you she has come to see you because she has lost her job recently and is experiencing intense daily anger and sadness about this and is having difficulty letting it go and moving on to search for other work. Her executive recruiter told her to get some help with her anger.

A single executive in her mid-30s, Sophie would say with a smile that her Achilles' heel was her "weakness for good-looking men". When an attractive man indicated to Sophie that he was interested in her sexually, she found herself unable to resist, or more accurately, she found herself unable to want to resist. She experienced herself almost as a victim, sexually drawn to men against her will. It felt similar to when her swim coach used to flirt with her when she was 13.

When Sophie discovered online chat groups she suddenly had access to all sorts of men online who seemed to be interested in being sexual with her. Her friends said it was the only time they saw her show any interest in anything these days given how bored she had been saying she was with everything in her life. She began emailing back and forth with several men whom she had never met before but had encountered on the Internet chat groups. It escalated.

Over a few weeks she began spending 4-5 hours during the workday checking and responding to her email. Soon she and various men online began to instant message (IM) each other. In this way they became constantly available to each other online throughout the workday. She went to her office earlier and stayed at work later so she could stay online later. Then it became weekends too. In some ways she felt she had to be tapped into what was happening online in these chat groups at all times, otherwise she felt upset and anxious. When she started losing lots of weight very quickly she reasoned it was because she had been working so hard. Her friend told her she seemed restless and fidgety all the time now, and she barely slept. Instead she would stay up all night composing emails in her head or fantasizing about what might happen if she met any of the online men in person. As a result Sophie felt exhausted almost every day.

When some of the men she was communicating with online started asking to meet with her, Sophie, again, found herself unable to say "no". She began meeting with the men over her lunch hour. Meetings in coffee shops became meetings in her apartment and rapidly progressed from flirtations to sex. At first Sophie felt guilty about having sex with men she hardly knew at all but she brushed these feelings aside telling herself she was a modern woman. Sophie's fiancé ended their engagement after she repeatedly broke promises to him that she would stop sleeping with other men. After the breakup Sophie felt worthless and terribly guilty for months, but this did not stop her from continuing to meet with the men from online.

When Sophie began to use her apartment in the city for midday sexual liaisons, her lunch breaks stretched longer and longer. Her formerly superior work performance began to slacken and she did not receive an expected promotion. At work, Sophie had a hard time thinking or concentrating on the tasks in front of her. She was frequently bothered by intruding graphic sexual images from her online chats, which she would then try to ignore. Sophie's boss warned her that she could lose her job if she was unable to keep business and personal separate in her life. Sophie resolved that she would turn over a new leaf and for six weeks she kept her sexual behaviour in check, disconnected her internet access at work and stopped visiting the online chat groups.

Then, when she was working late one night and had just finished a big project, she noticed that her neck and back were tight, and told herself she would just unwind a little with a quick visit to the online chat group. As she logged in, in the back of her mind, a tiny thought that her need to go online felt too strong was quickly quieted. Within minutes she was instant messaged by one of the men online for a sexual rendezvous. Since there was no one at the office at this late hour, Sophie justified that it would be alright. When a male co-worker walked in on her sexual activities, Sophie knew their might be repercussions, yet she continued to liase with men from the online chat group during her lunch hours. At the same time the co-worker who had walked in on Sophie began to pressure her for sexual favours. When she brushed him off, he disclosed to the boss Sophie's after hours office activities. Since this was against company policy, she was fired immediately. Since being fired Sophie has been having frequent intrusive thoughts about killing herself by driving her car off the road.

Feedback regarding above CASE 2 vignette (Sophie):

CASE 2 – QUESTION 1.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Sophie).

A ranking of '1' means that you believe this to be THE PRIMARY PROBLEM in need of therapeutic attention, while a ranking of '5' means that you believe this to be THE MOST PERIPHERAL PROBLEM in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

	Ranking
Delirium, dementia, or other cognitive disorder	
Substance-Induced Mood Disorder (manic features)	
Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)	
Major Depressive Disorder – Single Episode	
Major Depressive Disorder – Recurrent	
Dysthymic Disorder	
Depressive Disorder NOS	
Bipolar I Disorder	
Bipolar II Disorder	
Cyclothymic Disorder	
Obsessive-Compulsive Disorder	
Posttraumatic Stress Disorder	
Hypoactive Sexual Desire Disorder	
Dissociative Disorder	
Delusional Disorder (erotomania)	
Paraphilia	
Paraphilia NOS	
Sex Addiction	
Cybersex Addiction	
Gender Identity Disorder in Adults	

Sexual Disorder NOS	
Impulse-Control Disorder NOS	
Adjustment Disorder (disturbance of conduct)	
Borderline Personality Disorder	
Avoidant Personality Disorder	
Relational Problems	
Religious or Spiritual Problem	
Phase of Life Problem	
Unspecified Mental Disorder (nonpsychotic)	

Feedback regarding the items in QUESTION 1 above for Case 2 (Sophie):

CASE 2 – QUESTION 2.

Instructions: By selecting only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Sophie).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

10. Insomnia or hypersomnia nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

12. Psychomotor agitation or retardation nearly every day observable by others

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

16. Fatigue or loss of energy nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

17. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

18. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

Feedback regarding the items in QUESTION 2 above for Case 2 (Sophie):

CASE 3 – BILL.

Bill tells you he has come to see you because he was has lost his marriage and is feeling depressed and suicidal. His pastor suggested Bill get some support coping with the loss of his marriage and referred Bill to you.

An electrician in his mid-20s, married for 3 years, Bill had masturbated nearly every night before going to sleep since his middle teens when he first discovered online porn pictures and videos. When he quit using alcohol and other drugs in his early 20s, his sexual fantasies and urges became more frequent and more intense. At about the same time his wife and his sister started commenting that Bill appeared to be depressed and uninterested in the things he used to do, moping about the house when home and not seeing his friends anymore.

He began to experience strong urges to masturbate in the morning, usually after having had a hard time getting to sleep, which was a frequent occurrence. He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife. During these times, his wife and coworkers would notice and tell Bill to relax and that he was making them nervous because he was so jumpy. Consequently, he started to view online porn and masturbate before work, even though he would sometimes arrive late, dazed and zoned out as a result.

Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours. Bill would search for hours for sexual images, sorting them into meticulous categories and folders and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his private locker at work. As he searched he would become more and more tense but the organizing of the images seemed to soothe him. When Bill would find the "perfect" image he would stop searching and masturbate to it. The process so consumed him that he lost interest in food.

No longer sufficiently excited by viewing porn online, Bill began to purchase online "live" strippers and "live" streaming videos of sexual acts. He couldn't stop thinking about porn and what he'd seen online even when he so desperately wanted to pay attention to his wife. He wife caught him watching "live" porn at home one day and told him if he didn't stop she would leave him. He also received a second warning about tardiness and inattentiveness at work. He felt disgusted with himself and started to have recurring thoughts of killing himself and escaping all the problems; but each time he tried to stop going online to surf for sex, he would fail.

Sexual images and fantasies accompanied by arousal would intrude into his consciousness throughout the day, whether he wanted them to or not, and he would feel as though he was going to explode. At night Bill was having difficulty sleeping, feeling jittery and unable to relax with sexual images swirling through his head, resulting in exhaustion during the day. The only thing that would make them go away was logging back online to search for and look at more sex sites. He occasionally thought to himself that this was crazy and that he was stuck in a never-ending loop.

When his wife became pregnant, he deleted his collection of online pornography and his list of online favorites and resolved to quit masturbating. Within a few months, though, he again lost control of his online surfing and masturbation and the marriage soon fell apart. Before long he had "maxed-out" his credit cards. Socially isolated, deeply in debt, suicidal, and about to lose his job, Bill felt powerless and worthless.

Feedback regarding above CASE 3 vignette (Bill):

CASE 3 – QUESTION 1.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Bill).

A ranking of '1' means that you believe this to be THE PRIMARY PROBLEM in need of therapeutic attention, while a ranking of '5' means that you believe this to be THE MOST PERIPHERAL PROBLEM in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

	Ranking
Delirium, dementia, or other cognitive disorder	
Substance-Induced Mood Disorder (manic features)	
Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)	
Major Depressive Disorder – Single Episode	
Major Depressive Disorder – Recurrent	
Dysthymic Disorder	
Depressive Disorder NOS	
Bipolar I Disorder	
Bipolar II Disorder	
Cyclothymic Disorder	

Obsessive-Compulsive Disorder	
Posttraumatic Stress Disorder	
Hypoactive Sexual Desire Disorder	
Dissociative Disorder	
Delusional Disorder (erotomania)	
Paraphilia	
Paraphilia NOS	
Sex Addiction	
Cybersex Addiction	
Gender Identity Disorder in Adults	
Sexual Disorder NOS	
Impulse-Control Disorder NOS	
Adjustment Disorder (disturbance of conduct)	
Borderline Personality Disorder	
Avoidant Personality Disorder	
Relational Problems	
Religious or Spiritual Problem	
Phase of Life Problem	
Unspecified Mental Disorder (nonpsychotic)	

Feedback regarding the items in QUESTION 1 above for Case 3 (Bill):

CASE 3 – QUESTION 2.

Instructions: By selecting only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Bill).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

10. Insomnia or hypersomnia nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

12. Psychomotor agitation or retardation nearly every day observable by others

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

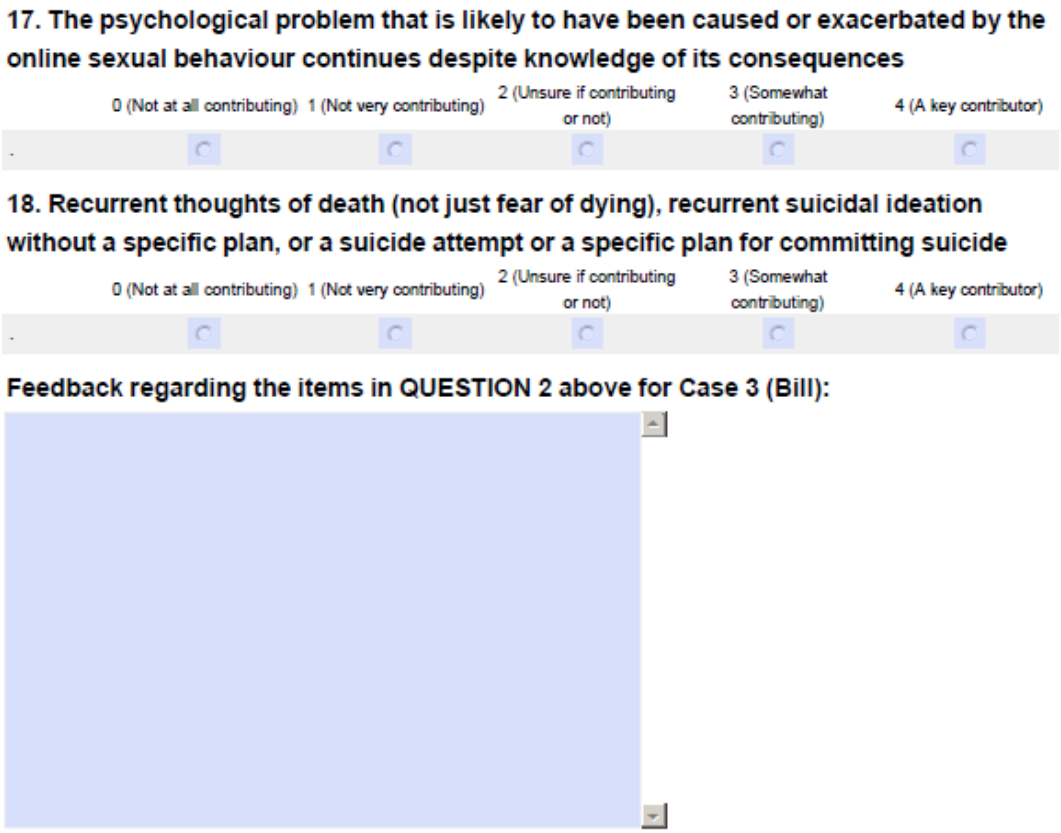
	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					

16. Fatigue or loss of energy nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.					



CVSI-V2 Question 2 Cybersex Addiction (CSA) Subscale Scoring Protocol:

(1) Maintain the same coding of 0-4
(2) Compare scores for items #1 and #3 and select only the one score that is highest OR if the scores are the same only select one of them. This new selected score will be called “High score b/w item #1 and #3”.
(3) Compare scores for items #5 and #7 and select only the one score that is highest OR if the scores are the same only select one of them. This new selected score will be called “High score b/w item #5 and #7”.
(4) Add the outcome of steps 2 and 3 above
(5) Add together items #9, 11, 13, 15 and 17
(6) Add the outcome of steps 4 and 5 above (i.e., CSA Subscale Score = (“High score b/w item #1 and #3” + “High score b/w item #5 and #7”) + (item#9 + item#11 + item#13 + item#15 + item#17))
(7) A score on a continuum from 0-28 will be generated by this formula. Scores greater than or equal to 9 will indicate endorsement of the “diagnosis” of Cybersex Addiction. Scores less than 9 will indicate lack of endorsement of the “diagnosis” of Cybersex Addiction”.

Appendix W

Summary of CVSI Questions 1 & 2 Quantitative Feedback from Expert Validators - Pilot (Phase I)

CVSI-V1 Question 1 (later in CVSI-V2 known as Question 2)												
Subscales		Case Vignettes										
		1) Sophie			2) Bill			3) Jeff				
	Minimum Subscale Endorsement	Accurate built in signal strength	Expert Validator #1 (CVSI-V1)	Expert Validator #3 (CVSI-V2)	Accurate built in signal strength	Expert Validator #1 (CVSI-V1)	Expert Validator #3 (CVSI-V2)	Accurate built in signal strength	Expert Validator #1 (CVSI-V1)	Expert Validator #3 (CVSI-V2)		
CSA	9	12	25	22	21	23	28	6	5	19		
MDD	18	15	0	--	15	25	--	18	27	--		
OCD-Obsessions	18	6	15	--	12	16	--	9	0	--		
OCD-Compulsions	12	12	13	--	9	11	--	0	0	--		

CVSI-V1 Question 2 (later in CVSI-V2 known as Question 1)															
CASE	Likert Rating Label	Primary problem in need of therapeutic attention		Primary problem in need of therapeutic attention		2		3		4		Most peripheral problem in need of therapeutic attention		Problem not in need of therapeutic attention	
	Likert Rating	1		1 group		2		3		4		5		0	
	Expert Validator (EV)	EV1	EV3	EV1	EV3	EV1	EV3	EV1	EV3	EV1	EV3	EV1	EV3	EV1	EV3
SOPHIE	SA	X	X	X	X	--	--	--	--	--	--	--	--	--	--
	CSA	X	--			--	X	--	--	--	--	--	--	--	--
	MDD-SE	--	--	--	--	--	--	--	--	X	X	--	--	--	--
	MDD-RE	--	--			--	--	X	--	--	--	--	--	--	X
	OCD	--	--	--	--	--	--	X	X	--	--	--	--	--	--
	Other	--	--	--	--	12, 14, 26, 27	--	3, 17	--	--	--	1, 2, 6-10, 13, 15, 16, 20-25, 28, 19	22	--	1-3, 6-10, 12-17, 20, 21, 23-29
BILL	SA	X	--	X	X	--	--	--	--	--	--	--	--	--	X
	CSA	--	X			X	--	--	--	--	--	--	--	--	--
	MDD-SE	--	--	--	--	--	--	--	--	--	--	X	--	--	X
	MDD-RE	--	--			--	--	--	--	--	--	X	X	--	--
	OCD	--	--	--	--	--	--	--	X	--	--	X	--	--	--
	Other	7	--	--	--	25-27	26	--	--	--	22	1-3, 6, 8-17, 20-24, 28, 29	--	--	1-3, 6-10, 12-17, 20, 21, 23-25, 27-29
JEFF	SA	X	--	X	X	--	--	--	--	--	--	--	--	--	X
	CSA	--	X			--	--	--	--	--	--	X	--	--	--
	MDD-SE	--	--	--	--	X	--	--	--	--	--	--	--	--	X
	MDD-RE	--	--			--	--	--	--	--	--	X	--	--	X
	OCD	--	--	--	--	--	--	--	--	--	--	X	X	--	--
	Other	--	--	--	--	23, 26	26	--	27	--	21	1-3, 6-10, 12-17, 20-22, 24, 25, 27-29	--	--	1-3, 6-10, 12-17, 20, 22-25, 28, 29

1	Delirium, dementia, or other cognitive disorder
2	Substance-Induced Mood Disorder (manic features)
3	Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)
4	Major Depressive Disorder – Single Episode
5	Major Depressive Disorder – Recurrent
6	Dysthymic Disorder
7	Depressive Disorder NOS
8	Bipolar I Disorder
9	Bipolar II Disorder
10	Cyclothymic Disorder
11	Obsessive-Compulsive Disorder
12	Posttraumatic Stress Disorder
13	Hypoactive Sexual Desire Disorder
14	Dissociative Disorder
15	Delusional Disorder (erotomania)
16	Paraphilia
17	Paraphilia NOS
18	Sex Addiction
19	Cybersex Addiction
20	Gender Identity Disorder in Adults
21	Sexual Disorder NOS
22	Impulse-Control Disorder NOS
23	Adjustment Disorder (disturbance of conduct)
24	Borderline Personality Disorder
25	Avoidant Personality Disorder
26	Relational Problems
27	Religious or Spiritual Problem
28	Phase of Life Problem
29	Unspecified Mental Disorder (nonpsychotic)

Appendix X

Summary of CVSI Questions 1 & 2 Qualitative Feedback from Expert Validators - Pilot (Phase I)

CVSI Version	Expert Validators	Case Vignettes			Question Items	
		Sophie	Bill	Jeff	Q1 (relabelled Q2 in CVSI-V2)	Q2 (relabelled Q1 in CVSI-V2)
	EV#1	"Reflects accurately online sexual addiction with underlying trauma reenactment at it core."	"none"	--	"...some questions confusing,need editng."	"....need category of "not at all" 0 (zero)..."
CVSI-V1	EV#2	"I think you've done a good job in your cases including material that complies with the diagnostic criteria, including your operationalization of CSA."			"You also have follow-up questions that afford the opportunity for raters to endorse particular aspects of the problem and the respective level of contribution to the problem." ---- "Also, I think you have too many questions after the cases. Limit your questions to 10 max." ---- "I think it would be nice to have an open ended question that says something like 'In two or three sentences, describe how you conceptualize this case and what would be the focus of clinical attention.'"	"... I love what you've done with Question 2 after each case where respondents can you do follow-up with ranking.) This is excellent."
CVSI-V2	EV#3	"This is a lot more classical of a severe sexual addiction case with some of the women I've seen. The only thing that I would comment on would be the infrequency of the severity of this case in my practice. Typically the severities are much less but still problematic."	"Another good classic case. the typical severity though tends to be lower by the time they come into session with me."	"generally a good case. I would say that the case fills a lot of the criteria met by clients. The noticeable parts which are not typical, but occassionally seen in my practice are the localized levels of masturbation considering his thought level and the flavour of the HIGH level of depression/guilt. In a case like this even with the strong religious upbringing my experience is the guilt tends to be MORE associated with trying to not be caught by their partner/deception and the depression is MORE related to their lack of sleep...but those are jsut nuances. thats all really."	"good"	"You could add in the adjustment disorders (generally speaking) or some of the V codes regarding occupational problem.." ---- "good" ---- "...you might want to consider putting something regarding eating disorders in as well..."

Appendix Y

CPA Recruitment Email - Phase II

STUDY ABOUT THE ROLE OF THERAPISTS' CHARACTERISTICS IN THEIR PERCEPTIONS OF CLIENTS' PRESENTING PROBLEMS

Principal Investigator: Easter Yassa, M.A.

Purpose of the research: fulfillment of dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta, Edmonton, Alberta.

Dear Colleague,

There is very little research that examines the relationship between the person of the therapist and his/her perception of the client's presenting concerns. You are invited to participate in the research study linked to this email, which was developed in an effort to learn more about how some of the characteristics of counsellors/therapists might influence their perception of the problems with which clients present to therapy. I am conducting this research to fulfill the dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta and my Dissertation Supervisor is Dr. George Buck. If you are a registered psychologist or psychological associate AND are currently practicing your participation in this research and completion of the enclosed surveys would be very valuable and greatly appreciated.

I recognize that as a professional psychologist or psychological associate your time is limited and I appreciate your participation in this important research project. Your participation is expected to take approximately 30 – 35 minutes. I believe that the results will be valuable in helping psychologists/psychological associates in their work and would be glad to share the findings with you. If you are willing to participate in this study please click here: https://www.surveymonkey.com/s/therapistscharacteristicsphdresearch1 to access the online informed consent form and survey. Your participation is vital to this study so the results will be representative of psychologists/psychological associates provincially. The information will be used to recommend areas for additional training and/or exploration for practising clinicians and graduate students in psychology.

If you have questions about this study you may contact me, Easter Yassa, at the Department of Educational Psychology, 6-102 Education North, University of Alberta, Edmonton, AB, T6G 2G5 or via email at eyassa@ualberta.ca or by phone at 780- 504-3363. Additionally, you may reach my Dissertation Supervisor, Dr. George Buck, with any questions via email at george.buck@ualberta.ca .

Thank you very much in advance for your help with this important research. Please click the button below to proceed to the online informed consent form.

YES – I'M INTERESTED IN PARTICIPATING.

Click here: https://www.surveymonkey.com/s/therapistscharacteristicsphdresearch1

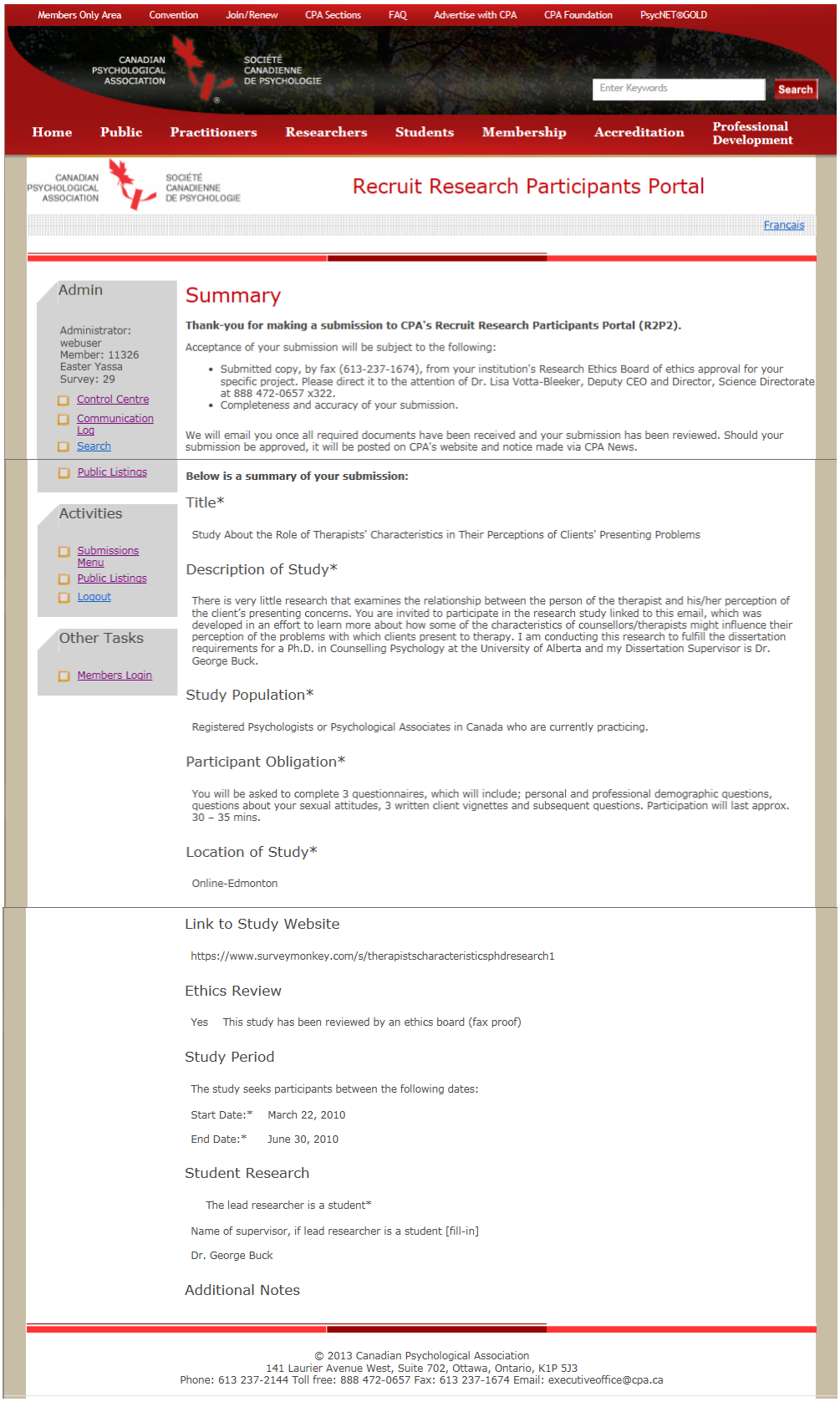
Sincerely,

Easter Yassa, M.A., Ph.D. Student (Counselling Psychology)
Faculty of Education, Department of Educational Psychology
University of Alberta

Dr. George Buck, Dissertation Supervisor, Associate Chair & Graduate Coordinator
Faculty of Education, Department of Educational Psychology
University of Alberta

Appendix Z

CPA Recruit Research Participants Portal (R2P2) Recruitment Post - Phase II



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Recruit Research Participants Portal

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Administrator: webuser
Member: 11326
Easter Yassa
Survey: 29

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Summary

Thank-you for making a submission to CPA's Recruit Research Participants Portal (R2P2).

Acceptance of your submission will be subject to the following:

- Submitted copy, by fax (613-237-1674), from your institution's Research Ethics Board of ethics approval for your specific project. Please direct it to the attention of Dr. Lisa Votta-Bleeker, Deputy CEO and Director, Science Directorate at 888 472-0657 x322.
- Completeness and accuracy of your submission.

We will email you once all required documents have been received and your submission has been reviewed. Should your submission be approved, it will be posted on CPA's website and notice made via CPA News.

Below is a summary of your submission:

Title*

Study About the Role of Therapists' Characteristics in Their Perceptions of Clients' Presenting Problems

Description of Study*

There is very little research that examines the relationship between the person of the therapist and his/her perception of the client's presenting concerns. You are invited to participate in the research study linked to this email, which was developed in an effort to learn more about how some of the characteristics of counsellors/therapists might influence their perception of the problems with which clients present to therapy. I am conducting this research to fulfill the dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta and my Dissertation Supervisor is Dr. George Buck.

Study Population*

Registered Psychologists or Psychological Associates in Canada who are currently practicing.

Participant Obligation*

You will be asked to complete 3 questionnaires, which will include; personal and professional demographic questions, questions about your sexual attitudes, 3 written client vignettes and subsequent questions. Participation will last approx. 30 – 35 mins.

Location of Study*

Online-Edmonton

Link to Study Website

https://www.surveymonkey.com/s/therapistscharacteristicsphdresearch1

Ethics Review

Yes This study has been reviewed by an ethics board (fax proof)

Study Period

The study seeks participants between the following dates:

Start Date:* March 22, 2010

End Date:* June 30, 2010

Student Research

The lead researcher is a student*

Name of supervisor, if lead researcher is a student [fill-in]

Dr. George Buck

Additional Notes

© 2013 Canadian Psychological Association
141 Laurier Avenue West, Suite 702, Ottawa, Ontario, K1P 5J3
Phone: 613 237-2144 Toll free: 888 472-0657 Fax: 613 237-1674 Email: executiveoffice@cpa.ca

March 22, 2010

Dear Easter Yassa,

Thank you for submitting your research abstract to CPA's Recruit Research Participant Portal (R2P2).

You can view or print your research protocol at any time by visiting:

https://web.cpa.ca/r2p2/index.php?page=research&survey=29&member=11326&password=Yassa

Staff review of your submission has occurred and we are pleased to notify you that your submission has been accepted for posting.

If there are any changes to your submission or contact information, please ensure that you promptly notify us of these changes.

Unless otherwise stated in your submission, CPA will post your abstract on its website for one month, contingent on acceptance and upon receipt of ethics approval.

Please note that CPA does not guarantee participant recruitment via this portal nor does it bear any responsibility for participants' experience participating in your study.

Should you have any questions or concerns, please do not hesitate to contact me directly.

Sincerely,

Lisa Votta-Bleeker
Associate Executive Director
Canadian Psychological Association
141 Laurier Street W, Suite 702
Ottawa, Ontario, KIP 5J3
Telephone: (613) 237-2144 X 322
Toll Free: (888) 472-0657 X 322
Fax: (613) 237-1674
E-mail:executiveoffice@cpa.ca
Web: www.cpa.ca

Appendix AA

PAA Mailed Recruitment Letter - Phase II

UNIVERSITY OF ALBERTA

Department of Educational Psychology
Faculty of Education

6-102 Education North
Edmonton, Alberta, Canada T6G 2G5

www.uofaweb.ualberta.ca/edpsychology

Tel: 780.492.5245
Fax: 780.492.1318

Date: 29/03/2010

Dear Colleague,

There is very little research that examines the relationship between the person of the therapist and his/her perception of the client's presenting concerns. You are invited to participate in the research study enclosed in this package, which was developed in an effort to learn more about how some of the characteristics of counsellors/therapists might influence their perception of the problems with which clients present to therapy. I am conducting this research to fulfill the dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta and my Dissertation Supervisor is Dr. George Buck. **If you are a registered psychologist or psychological associate AND are currently practicing** your participation in this research and completion of the enclosed surveys would be very valuable and greatly appreciated.

I recognize that as a professional psychologist or psychological associate your time is limited and I appreciate your participation in this important research project. Your participation is expected to take 30 – 35 minutes. I believe that the results will be valuable in helping psychologists/ psychological associates in their work and would be glad to share the findings with you. If you are willing to participate in this study please read the enclosed informed consent form. It is vital to this study that you return the paper surveys, or complete them online at www.surveymonkey.com/s/therapistscharacteristicsphdresearch1, so the results will be representative of psychologists provincially. The information will be used to recommend areas for additional training and/or exploration for practising clinicians and graduate students in psychology.

If you have questions about this study you may contact me, Easter Yassa, at the Department of Educational Psychology, 6-102 Education North, University of Alberta, Edmonton, AB, T6G 2G5 or via email at eyassa@ualberta.ca or by phone at 780- 504-3363. Additionally, you may reach my Dissertation Supervisor, Dr. George Buck, with any questions via email at george.buck@ualberta.ca .

Thank you very much in advance for your help with this important research.

Sincerely,

Easter Yassa, MA, Ph.D. Student (Counselling Psychology)
Faculty of Education, Department of Educational Psychology
University of Alberta

Dr. George Buck, Dissertation Supervisor, Associate Chair & Graduate Coordinator
Faculty of Education, Department of Educational Psychology
University of Alberta

Appendix BB

PAA Online Recruitment Online Flyer - Phase II

STUDY ABOUT THE ROLE OF THERAPISTS' CHARACTERISTICS IN THEIR PERCEPTIONS OF CLIENTS' PRESENTING PROBLEMS

Principal Investigator: Easter Yassa, M.A.
Purpose of the research: fulfillment of dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta, Edmonton, Alberta.

Are you a registered psychologist or psychological associate?

Are you currently practicing?

If you answered yes to both questions you are invited to participate in an anonymous study to examine if there is a relationship between therapists' characteristics and their perceptions of the presenting problems of their clients. My name is Easter Yassa and I am conducting this study to fulfill dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta.

By participating you get the benefit of knowing that you have contributed something valuable to the knowledge base of your profession and have assisted indirectly in helping other therapists (including graduate students and seasoned professionals) learn about their role in the therapeutic assessment process.

I realize that it takes time to complete surveys and I want you to know in advance that I sincerely appreciate the time and effort that you are investing in this research. If you decide you would like to participate, when you are ready click here http://www.surveymonkey.com/s/therapistscharacteristicsphdresearch2 or below to access the informed consent form online. Please read the informed consent form and, if you agree with the terms, follow the instructions to complete the surveys online. I anticipate that completion of the three surveys enclosed will take approximately 30 – 35 minutes.

I want to take this opportunity again to thank you for your time. Without your cooperation this research would not be possible.

YES – I'M INTERESTED IN PARTICIPATING.
Click here: www.surveymonkey.com/s/therapistscharacteristicsphdresearch2

Sincerely,

Easter Yassa, M.A., Ph.D. Student (Counselling Psychology)
Department of Education, University of Alberta
6-102 Education North, University of Alberta, Edmonton, AB, T6G 2G5
Tel: 780- 504-3363
Email: eyassa@ualberta.ca

Appendix CC

CVSI-V3 and CSA Subscale Scoring Protocol - Online Version (Phase II)

CASE 1 – JEFF.

Jeff tells you he has come to see you because he is feeling very anxious about the hospital Chief of Staff's recommendation that he take some time off work and is worried about his career. Jeff, a married neurologist in his 40s, feels tired, without energy, and is having difficulty concentrating all the time now. It doesn't seem to matter how much time he sets aside for sleep, he just never sleeps more than 2-3 hours a night. This has been going on for 2 months.

In his marriage, sex was among one of the main sources of tension. He thought and fantasized about it all the time. His wife said he seemed to have lost interest in the things he used to enjoy. He thought about having sex almost constantly, accompanied by feelings of intense nervousness that his wife would turn him down again if he asked. Jeff had grown up Catholic and every time he had a fantasy pop into his head he would mentally run through the Lord's prayer in hopes that it would stop the sexual thoughts intruding into his head and reduce his urge to have sex. He knew his mind had worked this way since he was a young man. Growing up and even now he often had the feeling that he was struggling with these thoughts more than his other male friends.

Just like with previous girlfriends, Jeff often felt desperate and feared that his wife did not love him and that he was not good enough for her. These feelings were even more present when his wife declined sex. Jeff was spending a lot of time feeling intensely guilty nearly every day about his desire for sex. On such occasions, and sometimes to interrupt the almost constant thoughts of sex, he withdrew to his study and immersed himself in work, rechecking patient diagnoses. Sometimes for a few hours a night several times a week he would attempt to get his sexual needs met by reading online erotica and masturbating, but he did not seek sex elsewhere. Sometimes he felt guilty about looking online for sexual release but he didn't know what else to do.

When Jeff wasn't working and thinking about sex he was eating. In fact, he and his wife and colleagues had noticed that he had gained 10-15 lbs in the last month alone. When his wife's inflammatory bowel disease flared up, Jeff cared for her sensitively, and she expressed her appreciation and gratitude. At such times, Jeff felt needed and valued and rarely thought of sex. Jeff's desire for sex occasionally offended his wife, who felt then that he would rather have sex than talk with her. Sometimes when Jeff's wife complied with his requests for sex, she resented him. At those times Jeff would think a lot about dying and the sense of relief it might bring from the cycle of misery he felt he was in. He never did anything about it though.

Several of Jeff's colleagues had commented to him in the last couple of weeks that he didn't look his usual brisk self, and that he looked slowed down and depressed. The Chief of Staff had called Jeff into his office and indicated that perhaps Jeff should seek counselling from the hospital EAP, and maybe take some time off work after completing his backlog of incomplete patient charts.

CASE 1 – QUESTION 1.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Jeff).

CASE 1 – QUESTION 2.

Instructions: By selecting only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Jeff).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

10. Insomnia or hypersomnia nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

12. Psychomotor agitation or retardation nearly every day observable by others

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

16. Fatigue or loss of energy nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

17. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

18. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

CASE 2 - SOPHIE.

Sophie tells you she has come to see you because she has lost her job recently and is experiencing intense daily anger and sadness about this and is having difficulty letting it go and moving on to search for other work. Her executive recruiter told her to get some help with her anger.

A single executive in her mid-30s, Sophie would say with a smile that her Achilles' heel was her "weakness for good-looking men". When an attractive man indicated to Sophie that he was interested in her sexually, she found herself unable to resist, or more accurately, she found herself unable to want to resist. It felt similar to when her swim coach used to flirt with her when she was 13.

When Sophie discovered online chat groups she suddenly had access to all sorts of men online who seemed to be interested in being sexual with her. Her friends said it was the only time they saw her show any interest in anything these days given how bored she had been saying she was with everything in her life. She began emailing back and forth with several men whom she had never met before but had encountered on the internet chat groups. It escalated.

Over a few weeks she began spending 4-5 hours during the workday checking and responding to her email. Soon she and various men online began to instant message (IM) each other. In this way they became constantly available to each other online throughout the workday. She went to her office earlier and stayed at work later so she could stay online later. Then it became weekends too. In some ways she felt she had to be tapped into what was happening online in these chat groups at all times, otherwise she felt upset and anxious. When she started losing lots of weight very quickly she reasoned it was because she had been working so hard. Her friend told her she seemed restless and fidgety all the time now, and she barely slept. Instead she would stay up all night composing emails in her head or fantasizing about what might happen if she met any of the online men in person. As a result Sophie felt exhausted almost every day.

When some of the men she was communicating with online started asking to meet with her, Sophie agreed. She began meeting with the men over her lunch hour. Meetings in coffee shops became meetings in her apartment and rapidly progressed from flirtations to sex. At first Sophie felt guilty about having sex with men she hardly knew at all but she brushed these feelings aside telling herself she was a modern woman. Sophie's fiancé ended their engagement after she repeatedly broke promises to him that she would stop sleeping with other men. After the breakup Sophie felt worthless and terribly guilty for months, but this did not stop her from continuing to meet with the men from online.

When Sophie began to use her apartment in the city for midday sexual liaisons, her lunch breaks stretched longer and longer. Her formerly superior work performance began to slacken and she did not receive an expected promotion. At work, Sophie had a hard time thinking or concentrating on the tasks in front of her. She was frequently bothered by intruding graphic sexual images from her online chats, which she would then try to ignore. Sophie's boss warned her that she could lose her job if she was unable to keep business and personal separate in her life. Sophie resolved that she would turn over a new leaf and for six weeks she kept her sexual behaviour in check, disconnected her internet access at work and stopped visiting the online chat groups.

Then, when she was working late one night and had just finished a big project, she noticed that her neck and back were tight, and told herself she would just unwind a little with a quick visit to the online chat group. As she logged in, in the back of her mind, a tiny thought that her need to go online felt too strong was quickly quieted. Within minutes she was instant messaged by one of the men online for a sexual rendezvous. Since there was no one at the office at this late hour, Sophie justified that it would be alright. When a male co-worker walked in on her sexual activities, Sophie knew their might be repercussions, yet she continued to liase with men from the online chat group during her lunch hours. At the same time the co-worker who had walked in on Sophie began to pressure her for sexual favours. When she brushed him off, he disclosed to the boss Sophie's after hours office activities. Since this was against company policy, she was fired immediately. Since being fired Sophie has been having frequent intrusive thoughts about killing herself by driving her car off the road.

CASE 2 – QUESTION 1.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Sophie).

A ranking of '1' means that you believe this to be THE PRIMARY PROBLEM in need of therapeutic attention, while a ranking of '5' means that you believe this to be THE MOST PERIPHERAL PROBLEM in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

	Ranking
Delirium, dementia, or other cognitive disorder	
Substance-Induced Mood Disorder (manic features)	
Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)	
Major Depressive Disorder – Single Episode	
Major Depressive Disorder – Recurrent	
Dysthymic Disorder	
Depressive Disorder NOS	
Bipolar I Disorder	
Bipolar II Disorder	
Cyclothymic Disorder	
Obsessive-Compulsive Disorder	
Posttraumatic Stress Disorder	
Hypoactive Sexual Desire Disorder	
Dissociative Disorder	
Delusional Disorder (erotomania)	
Paraphilia	
Paraphilia NOS	
Sex Addiction	
Cybersex Addiction	
Gender Identity Disorder in Adults	
Sexual Disorder NOS	
Impulse-Control Disorder NOS	
Adjustment Disorder (disturbance of conduct)	
Borderline Personality Disorder	
Avoidant Personality Disorder	
Relational Problems	
Religious or Spiritual Problem	
Phase of Life Problem	
Unspecified Mental Disorder (nonpsychotic)	

CASE 2 – QUESTION 2.

Instructions: By selecting only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Sophie).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

10. Insomnia or hypersomnia nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

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11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

12. Psychomotor agitation or retardation nearly every day observable by others

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

16. Fatigue or loss of energy nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

17. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

18. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

CASE 3 – BILL.

Bill tells you he has come to see you because he was has lost his marriage and is feeling depressed and suicidal. His pastor suggested Bill get some support coping with the loss of his marriage and referred Bill to you.

An electrician in his mid-20s, married for 3 years, Bill had masturbated nearly every night before going to sleep since his middle teens when he first discovered online porn pictures and videos. When he quit using alcohol and other drugs in his early 20s, his sexual fantasies and urges became more frequent and more intense. At about the same time his wife and his sister started commenting that Bill appeared to be depressed and uninterested in the things he used to do, moping about the house when home and not seeing his friends anymore.

He began to experience strong urges to masturbate in the morning, usually after having had a hard time getting to sleep, which was a frequent occurrence. He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife. During these times, his wife and coworkers would notice and tell Bill to relax and that he was making them nervous because he was so jumpy. Consequently, he started to view online porn and masturbate before work, even though he would sometimes arrive late, dazed and zoned out as a result.

Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours. Bill would search for hours for sexual images, sorting them into meticulous categories and folders and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his private locker at work. As he searched he would become more and more tense but the organizing of the images seemed to soothe him. When Bill would find the "perfect" image he would stop searching and masturbate to it. The process so consumed him that he lost interest in food.

No longer sufficiently excited by viewing porn online, Bill began to purchase online "live" strippers and "live" streaming videos of sexual acts. He couldn't stop thinking about porn and what he'd seen online even when he so desperately wanted to pay attention to his wife. He wife caught him watching "live" porn at home one day and told him if he didn't stop she would leave him. He also received a second warning about tardiness and inattentiveness at work. He felt disgusted with himself and started to have recurring thoughts of killing himself and escaping all the problems; but each time he tried to stop going online to surf for sex, he would fail.

Sexual images and fantasies accompanied by arousal would intrude into his consciousness throughout the day, whether he wanted them to or not, and he would feel as though he was going to explode. At night Bill was having difficulty sleeping, feeling jittery and unable to relax with sexual images swirling through his head, resulting in exhaustion during the day. The only thing that would make them go away was logging back online to search for and look at more sex sites. He occasionally thought to himself that this was crazy and that he was stuck in a never-ending loop.

When his wife became pregnant, he deleted his collection of online pornography and his list of online favorites and resolved to quit masturbating. Within a few months, though, he again lost control of his online surfing and masturbation and the marriage soon fell apart. Before long he had "maxed-out" his credit cards. Socially isolated, deeply in debt, suicidal, and about to lose his job, Bill felt powerless and worthless.

CASE 3 – QUESTION 1.

Instructions: From the list below, please SELECT and RANK the TOP 5 presenting problems you believe to be illustrated in preceding case (Bill).

A ranking of '1' means that you believe this to be THE PRIMARY PROBLEM in need of therapeutic attention, while a ranking of '5' means that you believe this to be THE MOST PERIPHERAL PROBLEM in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

	Ranking
Delirium, dementia, or other cognitive disorder	
Substance-Induced Mood Disorder (manic features)	
Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)	
Major Depressive Disorder – Single Episode	
Major Depressive Disorder – Recurrent	
Dysthymic Disorder	
Depressive Disorder NOS	
Bipolar I Disorder	
Bipolar II Disorder	
Cyclothymic Disorder	
Obsessive-Compulsive Disorder	
Posttraumatic Stress Disorder	
Hypoactive Sexual Desire Disorder	
Dissociative Disorder	
Delusional Disorder (erotomania)	
Paraphilia	
Paraphilia NOS	
Sex Addiction	
Cybersex Addiction	
Gender Identity Disorder in Adults	

Sexual Disorder NOS	
Impulse-Control Disorder NOS	
Adjustment Disorder (disturbance of conduct)	
Borderline Personality Disorder	
Avoidant Personality Disorder	
Relational Problems	
Religious or Spiritual Problem	
Phase of Life Problem	
Unspecified Mental Disorder (nonpsychotic)	

CASE 3 – QUESTION 2.

Instructions: By selecting only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Bill).

A rating of '0' indicates that you believe the problem described to be NOT AT ALL CONTRIBUTING in the case above, while a rating of '4' indicates that you believe it to be A KEY CONTRIBUTOR.

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

10. Insomnia or hypersomnia nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

---

11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

12. Psychomotor agitation or retardation nearly every day observable by others

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

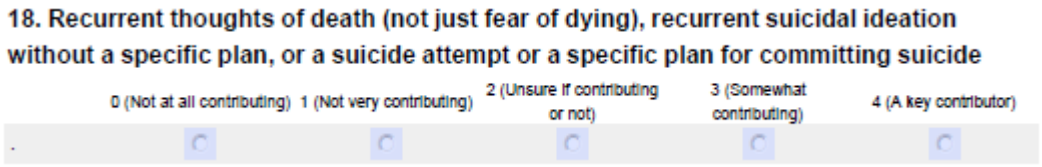
	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

16. Fatigue or loss of energy nearly every day

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○

17. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

	0 (Not at all contributing)	1 (Not very contributing)	2 (Unsure if contributing or not)	3 (Somewhat contributing)	4 (A key contributor)
.	○	○	○	○	○



CVSI-V3 Question 2 Cybersex Addiction (CSA) Subscale Scoring Protocol:

(1) Maintain the same coding of 0-4
(2) Compare scores for items #1 and #3 and select only the one score that is highest OR if the scores are the same only select one of them. This new selected score will be called “High score b/w item #1 and #3”.
(3) Compare scores for items #5 and #7 and select only the one score that is highest OR if the scores are the same only select one of them. This new selected score will be called “High score b/w item #5 and #7”.
(4) Add the outcome of steps 2 and 3 above
(5) Add together items #9, 11, 13, 15 and 17
(6) Add the outcome of steps 4 and 5 above (i.e., CSA Subscale Score = (“High score b/w item #1 and #3” + “High score b/w item #5 and #7”) + (item#9 + item#11 + item#13 + item#15 + item#17))
(7) A score on a continuum from 0-28 will be generated by this formula. Scores greater than or equal to 9 will indicate endorsement of the “diagnosis” of Cybersex Addiction. Scores less than 9 will indicate lack of endorsement of the “diagnosis” of Cybersex Addiction”.

Appendix DD

CVSI-V3 and CSA Subscale Scoring Protocol - Mailed Version (Phase II)

QUESTIONNAIRE #1

Below are 3 fictional client cases. After each case there are 2 sets of questions.

Please read through each case carefully in turn and answer the questions immediately following it.

Thank you.

Case 1 – Jeff.

Jeff tells you he has come to see you because he is feeling very anxious about the hospital Chief of Staff's recommendation that he take some time off work and is worried about his career. Jeff, a married neurologist in his 40s, feels tired, without energy, and is having difficulty concentrating all the time now. It doesn't seem to matter how much time he sets aside for sleep, he just never sleeps more than 2-3 hours a night. This has been going on for 2 months.

In his marriage, sex was among one of the main sources of tension. He thought and fantasized about it all the time. His wife said he seemed to have lost interest in the things he used to enjoy. He thought about having sex almost constantly, accompanied by feelings of intense nervousness that his wife would turn him down again if he asked. Jeff had grown up Catholic and every time he had a fantasy pop into his head he would mentally run through the Lord's prayer in hopes that it would stop the sexual thoughts intruding into his head and reduce his urge to have sex. He knew his mind had worked this way since he was a young man. Growing up and even now he often had the feeling that he was struggling with these thoughts more than his other male friends.

Just like with previous girlfriends, Jeff often felt desperate and feared that his wife did not love him and that he was not good enough for her. These feelings were even more present when his wife declined sex. Jeff was spending a lot of time feeling intensely guilty nearly every day about his desire for sex. On such occasions, and sometimes to interrupt the almost constant thoughts of sex, he withdrew to his study and immersed himself in work, rechecking patient diagnoses. Sometimes for a few hours a night several times a week he would attempt to get his sexual needs met by reading online erotica and masturbating, but he did not seek sex elsewhere. Sometimes he felt guilty about looking online for sexual release but he didn't know what else to do.

When Jeff wasn't working and thinking about sex he was eating. In fact, he and his wife and colleagues had noticed that he had gained 10-15 lbs in the last month alone. When his wife's inflammatory bowel disease flared up, Jeff cared for her sensitively, and she expressed her appreciation and gratitude. At such times, Jeff felt needed and valued and rarely thought of sex. Jeff's desire for sex occasionally offended his wife, who felt then that he would rather have sex than talk with her. Sometimes when Jeff's wife complied with his requests for sex, she resented him. At those times Jeff would think a lot about dying and the sense of relief it might bring from the cycle of misery he felt he was in. He never did anything about it though.

Several of Jeff's colleagues had commented to him in the last couple of weeks that he didn't look his usual brisk self, and that he looked slowed down and depressed. The Chief of Staff had called Jeff into his office and indicated that perhaps Jeff should seek counselling from the hospital EAP, and maybe take some time off work after completing his backlog of incomplete patient charts.

Case 1 – Question 1.

Instructions: From the list below, please *select* and *rank* the **TOP 5** presenting problems you believe to be illustrated in preceding case (Jeff).

A ranking of '1' means that you believe this to be *the primary problem* in need of therapeutic attention, while a ranking of '5' means that you believe this to be *the most peripheral problem* in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

____ Delirium, dementia, or other cognitive disorder

____ Substance-Induced Mood Disorder (manic features)

____ Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)

____ Major Depressive Disorder – Single Episode

____ Major Depressive Disorder – Recurrent

____ Dysthymic Disorder

____ Depressive Disorder NOS

____ Bipolar I Disorder

____ Bipolar II Disorder

____ Cyclothymic Disorder

____ Obsessive-Compulsive Disorder

____ Posttraumatic Stress Disorder

____ Hypoactive Sexual Desire Disorder

____ Dissociative Disorder

____ Delusional Disorder (erotomania)

____ Paraphilia

____ Paraphilia NOS

____ Sex Addiction

____ Cybersex Addiction

____ Gender Identity Disorder in Adults

____ Sexual Disorder NOS

____ Impulse-Control Disorder NOS

____ Adjustment Disorder (disturbance of conduct)

____ Borderline Personality Disorder

____ Avoidant Personality Disorder

____ Relational Problems

____ Religious or Spiritual Problem

____ Phase of Life Problem

____ Unspecified Mental Disorder (nonpsychotic)

Case 1 – Question 2.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Jeff).

A rating of '0' indicates that you believe the problem described to be *Not at all contributing* in the case above, while a rating of '4' indicates that you believe it to be *A key contributor*.

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

0 1 2 3 4

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

0 1 2 3 4

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

0 1 2 3 4

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

0 1 2 3 4

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

0 1 2 3 4

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

0 1 2 3 4

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

0 1 2 3 4

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

0 1 2 3 4

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

0 1 2 3 4

10. Insomnia or hypersomnia nearly every day

0 1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

0	1	2	3	4

12. Psychomotor agitation or retardation nearly every day observable by others

0	1	2	3	4

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

0	1	2	3	4

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

0	1	2	3	4

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

0	1	2	3	4

16. Fatigue or loss of energy nearly every day

0	1	2	3	4

17. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

0	1	2	3	4

18. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

0	1	2	3	4

Case 2 – Sophie.

Sophie tells you she has come to see you because she has lost her job recently and is experiencing intense daily anger and sadness about this and is having difficulty letting it go and moving on to search for other work. Her executive recruiter told her to get some help with her anger.

A single executive in her mid-30s, Sophie would say with a smile that her Achilles' heel was her "weakness for good-looking men". When an attractive man indicated to Sophie that he was interested in her sexually, she found herself unable to resist, or more accurately, she found herself unable to want to resist. It felt similar to when her swim coach used to flirt with her when she was 13.

When Sophie discovered online chat groups she suddenly had access to all sorts of men online who seemed to be interested in being sexual with her. Her friends said it was the only time they saw her show any interest in anything these days given how bored she had been saying she was with everything in her life. She began emailing back and forth with several men whom she had never met before but had encountered on the Internet chat groups. It escalated.

Over a few weeks she began spending 4-5 hours during the workday checking and responding to her email. Soon she and various men online began to instant message (IM) each other. In this way they became constantly available to each other online throughout the workday. She went to her office earlier and stayed at work later so she could stay online later. Then it became weekends too. In some ways she felt she had to be tapped into what was happening online in these chat groups at all times, otherwise she felt upset and anxious. When she started losing lots of weight very quickly she reasoned it was because she had been working so hard. Her friend told her she seemed restless and fidgety all the time now, and she barely slept. Instead she would stay up all night composing emails in her head or fantasizing about what might happen if she met any of the online men in person. As a result Sophie felt exhausted almost every day.

When some of the men she was communicating with online started asking to meet with her, Sophie agreed. She began meeting with the men over her lunch hour. Meetings in coffee shops became meetings in her apartment and rapidly progressed from flirtations to sex. At first Sophie felt guilty about having sex with men she hardly knew at all but she brushed these feelings aside telling herself she was a modern woman. Sophie's fiancé ended their engagement after she repeatedly broke promises to him that she would stop sleeping with other men. After the breakup Sophie felt worthless and terribly guilty for months, but this did not stop her from continuing to meet with the men from online.

When Sophie began to use her apartment in the city for midday sexual liaisons, her lunch breaks stretched longer and longer. Her formerly superior work performance began to slacken and she did not receive an expected promotion. At work, Sophie had a hard time thinking or concentrating on the tasks in front of her. She was frequently bothered by intruding graphic sexual images from her online chats, which she would then try to ignore. Sophie's boss warned her that she could lose her job if she was unable to keep business and personal separate in her life. Sophie resolved that she would turn over a new leaf and for six weeks she kept her sexual behaviour in check, disconnected her internet access at work and stopped visiting the online chat groups.

Then, when she was working late one night and had just finished a big project, she noticed that her neck and back were tight, and told herself she would just unwind a little with a quick visit to the online chat group. As she logged in, in the back of her mind, a tiny thought that her need to go online felt too strong was quickly quieted. Within minutes she was instant messaged by one of the men online for a sexual rendezvous. Since there was no one at the office at this late hour, Sophie justified that it would be alright. When a male co-worker walked in on her sexual activities, Sophie knew their might be repercussions, yet she continued to liase with men from the online chat group during her lunch hours. At the same time the co-worker who had walked in on Sophie began to pressure her for sexual favours. When she brushed him off, he disclosed to the boss Sophie's after hours office activities. Since this was against company policy, she was fired immediately. Since being fired Sophie has been having frequent intrusive thoughts about killing herself by driving her car off the road.

Case 2 – Question 1.

Instructions: From the list below, please *select* and *rank* the **TOP 5** presenting problems you believe to be illustrated in preceding case (Sophie).

A ranking of '1' means that you believe this to be *the primary problem* in need of therapeutic attention, while a ranking of '5' means that you believe this to be *the most peripheral problem* in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

____ Delirium, dementia, or other cognitive disorder

____ Substance-Induced Mood Disorder (manic features)

____ Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)

____ Major Depressive Disorder – Single Episode

____ Major Depressive Disorder – Recurrent

____ Dysthymic Disorder

____ Depressive Disorder NOS

____ Bipolar I Disorder

____ Bipolar II Disorder

____ Cyclothymic Disorder

____ Obsessive-Compulsive Disorder

____ Posttraumatic Stress Disorder

____ Hypoactive Sexual Desire Disorder

____ Dissociative Disorder

____ Delusional Disorder (erotomania)

____ Paraphilia

____ Paraphilia NOS

____ Sex Addiction

____ Cybersex Addiction

____ Gender Identity Disorder in Adults

____ Sexual Disorder NOS

____ Impulse-Control Disorder NOS

____ Adjustment Disorder (disturbance of conduct)

____ Borderline Personality Disorder

____ Avoidant Personality Disorder

____ Relational Problems

____ Religious or Spiritual Problem

____ Phase of Life Problem

____ Unspecified Mental Disorder (nonpsychotic)

Case 2 – Question 2.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Sophie).

A rating of '0' indicates that you believe the problem described to be *Not at all contributing* in the case above, while a rating of '4' indicates that you believe it to be *A key contributor*.

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

0 1 2 3 4

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

0 1 2 3 4

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

0 1 2 3 4

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

0 1 2 3 4

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

0 1 2 3 4

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

0 1 2 3 4

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

0 1 2 3 4

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

0 1 2 3 4

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

0 1 2 3 4

10. Insomnia or hypersomnia nearly every day

0 1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

0	1	2	3	4

12. Psychomotor agitation or retardation nearly every day observable by others

0	1	2	3	4

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

0	1	2	3	4

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

0	1	2	3	4

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

0	1	2	3	4

16. Fatigue or loss of energy nearly every day

0	1	2	3	4

17. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

0	1	2	3	4

18. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

0	1	2	3	4

Case 3 – Bill.

Bill tells you he has come to see you because he was has lost his marriage and is feeling depressed and suicidal. His pastor suggested Bill get some support coping with the loss of his marriage and referred Bill to you.

An electrician in his mid-20s, married for 3 years, Bill had masturbated nearly every night before going to sleep since his middle teens when he first discovered online porn pictures and videos. When he quit using alcohol and other drugs in his early 20s, his sexual fantasies and urges became more frequent and more intense. At about the same time his wife and his sister started commenting that Bill appeared to be depressed and uninterested in the things he used to do, moping about the house when home and not seeing his friends anymore.

He began to experience strong urges to masturbate in the morning, usually after having had a hard time getting to sleep, which was a frequent occurance. He found that if he did not act on these urges by going online and viewing porn, he would feel "horny" all day, which for him was associated with being restless, distracted and irritable both at work and towards his wife. During these times, his wife and coworkers would notice and tell Bill to relax and that he was making them nervous because he was so jumpy. Consequently, he started to view online porn and masturbate before work, even though he would sometimes arrive late, dazed and zoned out as a result.

Some months later, Bill began to daily use the one company computer to search for and view porn and masturbate at work as well, sometimes for hours. Bill would search for hours for sexual images, sorting them into meticulous categories and folders and burning them to CDs. Bill had compiled hundreds of CDs with these sexual images, which he kept carefully organized in his private locker at work. As he searched he would become more and more tense but the organizing of the images seemed to soothe him. When Bill would find the "perfect" image he would stop searching and masturbate to it. The process so consumed him that he lost interest in food.

No longer sufficiently excited by viewing porn online, Bill began to purchase online "live" strippers and "live" streaming videos of sexual acts. He couldn't stop thinking about porn and what he'd seen online even when he so desperately wanted to pay attention to his wife. He wife caught him watching "live" porn at home one day and told him if he didn't stop she would leave him. He also received a second warning about tardiness and inattentiveness at work. He felt disgusted with himself and started to have recurring thoughts of killing himself and escaping all the problems; but each time he tried to stop going online to surf for sex, he would fail.

Sexual images iimages and fantasies accompanied by arousal would intrude into his consciousness throughout the day, whether he wanted them to or not, and he would feel as though he was going to explode. At night Bill was having difficulty sleeping, feeling jittery and unable to relax with sexual images swirling through his head, resulting in exhaustion during the day. The only thing that would make them go away was logging back online to search for and look at more sex sites. He occasionally thought to himself that this was crazy and that he was stuck in a never-ending loop.

When his wife became pregnant, he deleted his collection of online pornography and his list of online favorites and resolved to quit masturbating. Within a few months, though, he again lost control of his online surfing and masturbation and the marriage soon fell apart. Before long he had "maxed-out" his credit cards. Socially isolated, deeply in debt, suicidal, and about to lose his job, Bill felt powerless and worthless.

Case 3 – Question 1.

Instructions: From the list below, please *select* and *rank* the **TOP 5** presenting problems you believe to be illustrated in preceding case (Bill).

A ranking of '1' means that you believe this to be *the primary problem* in need of therapeutic attention, while a ranking of '5' means that you believe this to be *the most peripheral problem* in need of the therapeutic attention.

Please ONLY SELECT 5 from the list below and ONLY RANK THOSE 5, leaving all others blank.

____ Delirium, dementia, or other cognitive disorder

____ Substance-Induced Mood Disorder (manic features)

____ Substance-Induced Anxiety Disorder (with obsessive-compulsive symptoms)

____ Major Depressive Disorder – Single Episode

____ Major Depressive Disorder – Recurrent

____ Dysthymic Disorder

____ Depressive Disorder NOS

____ Bipolar I Disorder

____ Bipolar II Disorder

____ Cyclothymic Disorder

____ Obsessive-Compulsive Disorder

____ Posttraumatic Stress Disorder

____ Hypoactive Sexual Desire Disorder

____ Dissociative Disorder

____ Delusional Disorder (erotomania)

____ Paraphilia

____ Paraphilia NOS

____ Sex Addiction

____ Cybersex Addiction

____ Gender Identity Disorder in Adults

____ Sexual Disorder NOS

____ Impulse-Control Disorder NOS

____ Adjustment Disorder (disturbance of conduct)

____ Borderline Personality Disorder

____ Avoidant Personality Disorder

____ Relational Problems

____ Religious or Spiritual Problem

____ Phase of Life Problem

____ Unspecified Mental Disorder (nonpsychotic)

Case 3 – Question 2.

Instructions: By circling only one number from 0 to 4 immediately beneath each item, please indicate the degree to which you believe that each of the problems listed below is contributing to the overall presenting problem of the client in the preceding case (Bill).

A rating of '0' indicates that you believe the problem described to be *Not at all contributing* in the case above, while a rating of '4' indicates that you believe it to be *A key contributor*.

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

1. A need for markedly increased amount or intensity of the online sexual behaviour to achieve the desired effect

0 1 2 3 4

2. Depressed mood most of the day, nearly every day, during the same 2-week period and representing a change from previous functioning

0 1 2 3 4

3. Markedly diminished effect with continued involvement in the online sexual behaviour at the same level of intensity

0 1 2 3 4

4. Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress

0 1 2 3 4

5. Characteristic psychophysiological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the online sexual behavior

0 1 2 3 4

6. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

0 1 2 3 4

7. The same (or a closely related) sexual behaviour is engaged in to relieve or avoid withdrawal symptoms

0 1 2 3 4

8. Significant weight loss when not dieting or weight gain (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

0 1 2 3 4

9. The online sexual behaviour is often engaged in over a longer period, in greater quantity, or at a higher level of intensity than was intended

0 1 2 3 4

10. Insomnia or hypersomnia nearly every day

0 1 2 3 4

Not at all contributing	Not very contributing	Unsure if contributing or not	Somewhat contributing	A key contributor
0	1	2	3	4

11. There is a persistent desire or unsuccessful efforts to cut down or control the online sexual behaviour

0	1	2	3	4

12. Psychomotor agitation or retardation nearly every day observable by others

0	1	2	3	4

13. A greater deal of time is spent in activities necessary to prepare for the online sexual behaviour, to engage in the behaviour, and to recover from its effects

0	1	2	3	4

14. Feeling driven to perform repetitive behaviors or mental acts in response to an obsession

0	1	2	3	4

15. Important social, occupational, or recreational activities are given up or reduced because of the online sexual behaviour

0	1	2	3	4

16. Fatigue or loss of energy nearly every day

0	1	2	3	4

17. The psychological problem that is likely to have been caused or exacerbated by the online sexual behaviour continues despite knowledge of its consequences

0	1	2	3	4

18. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

0	1	2	3	4

CVSI-V3 Question 2 Cybersex Addiction (CSA) Subscale Scoring Protocol:

(1) Maintain the same coding of 0-4
(2) Compare scores for items #1 and #3 and select only the one score that is highest OR if the scores are the same only select one of them. This new selected score will be called “High score b/w item #1 and #3”.
(3) Compare scores for items #5 and #7 and select only the one score that is highest OR if the scores are the same only select one of them. This new selected score will be called “High score b/w item #5 and #7”.
(4) Add the outcome of steps 2 and 3 above
(5) Add together items #9, 11, 13, 15 and 17
(6) Add the outcome of steps 4 and 5 above (i.e., CSA Subscale Score = (“High score b/w item #1 and #3” + “High score b/w item #5 and #7”) + (item#9 + item#11 + item#13 + item#15 + item#17))
(7) A score on a continuum from 0-28 will be generated by this formula. Scores greater than or equal to 9 will indicate endorsement of the “diagnosis” of Cybersex Addiction. Scores less than 9 will indicate lack of endorsement of the “diagnosis” of Cybersex Addiction”.

Appendix EE

SOS-R-M and Scoring Protocol - Online Version (Phase II)

Instructions: Please respond to each item as honestly as you can by selecting the box that best describes your feelings.

There are no right or wrong answers.

1. I think it would be very entertaining to look at erotica (sexually explicit Internet sites, chat rooms, books, magazines, movies, etc.).

I strongly agree — I strongly disagree

2. Erotica (sexually explicit Internet sites, chat rooms, books, magazines, movies, etc.) is obviously filthy and people should not try to describe it as anything else.

I strongly agree — I strongly disagree

3. Swimming in the nude with a member of the opposite sex would be an exciting experience.

I strongly agree — I strongly disagree

4. Masturbation can be an exciting experience.

I strongly agree — I strongly disagree

5. If I found out that a close friend of mine was a homosexual, it would annoy me.

I strongly agree — I strongly disagree

6. If people thought I was interested in oral sex, I would be embarrassed.

I strongly agree — I strongly disagree

7. Engaging in group sex is an entertaining idea.

I strongly agree — I strongly disagree

8. I personally find that thinking about engaging in sexual intercourse is arousing.

I strongly agree — I strongly disagree

9. Seeing an erotic (sexually explicit) movie/ on-line video/ Internet site/ on-line Chat/ magazine/ book would be sexually arousing to me.

I strongly agree — I strongly disagree

10. Thoughts that I may have homosexual tendencies would not worry me at all.

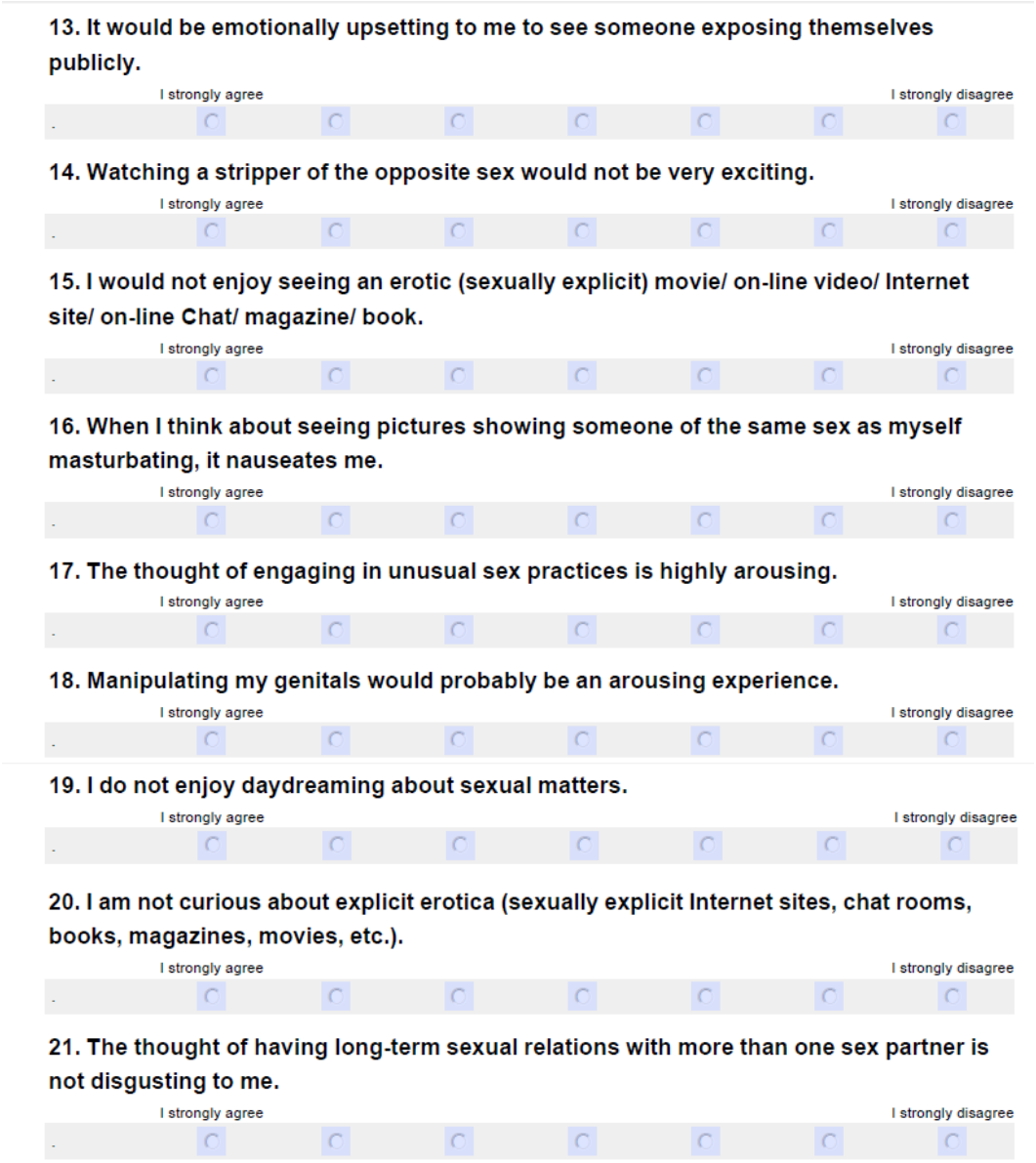
I strongly agree — I strongly disagree

11. The idea of my being physically attracted to members of the same sex is not depressing.

I strongly agree — I strongly disagree

12. Almost all erotic (sexually explicit) material is nauseating.

I strongly agree — I strongly disagree



SOS-R-M Scoring Protocol (Fisher, White, et al., 1988, P. 127):

1. Score responses from 1 = I strongly agree to 7 = I strongly disagree

2. Add scores from items 2, 5, 6, 12, 13, 14, 15, 16, 19, and 20

3. Subtract from this total the sum of items 1, 3, 4, 7, 8, 9, 10, 11, 17, 18, and 21

4. Add 67 to this quantity

Scores range from 0 (most erotophobic) to 126 (most erotophilic)

Appendix FF

SOS-R-M and Scoring Protocol - Mailed Version (Phase II)

QUESTIONNAIRE #2

Instructions:

Please respond to each item as honestly as you can by placing a check mark directly on the line that best describes your feelings.

There are no right or wrong answers.

1. **I think it would be very entertaining to look at erotica (sexually explicit Internet sites, chat rooms, books, magazines, movies, etc.).**

   I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

2. **Erotica (sexually explicit Internet sites, chat rooms, books, magazines, movies, etc.) is obviously filthy and people should not try to describe it as anything else.**

   I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

3. **Swimming in the nude with a member of the opposite sex would be an exciting experience.**

   I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

4. **Masturbation can be an exciting experience.**

   I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

5. **If I found out that a close friend of mine was a homosexual, it would annoy me.**

   I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

6. **If people thought I was interested in oral sex, I would be embarrassed.**

   I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

7. **Engaging in group sex is an entertaining idea.**

   I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

continued on next page…

8. I personally find that thinking about engaging in sexual intercourse is arousing.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

9. Seeing an erotic (sexually explicit) movie/ on-line video/ Internet site/ on-line Chat/ magazine/ book would be sexually arousing to me.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

10. Thoughts that I may have homosexual tendencies would not worry me at all.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

11. The idea of my being physically attracted to members of the same sex is not depressing.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

12. Almost all erotic (sexually explicit) material is nauseating.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

13. It would be emotionally upsetting to me to see someone exposing themselves publicly.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

14. Watching a stripper of the opposite sex would not be very exciting.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

15. I would not enjoy seeing an erotic (sexually explicit) movie/ on-line video/ Internet site/ on-line Chat/ magazine/ book.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

16. When I think about seeing pictures showing someone of the same sex as myself masturbating, it nauseates me.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

continued on next page…

17. The thought of engaging in unusual sex practices is highly arousing.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

18. Manipulating my genitals would probably be an arousing experience.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

19. I do not enjoy daydreaming about sexual matters.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

20. I am not curious about explicit erotica (sexually explicit Internet sites, chat rooms, books, magazines, movies, etc.).

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

21. The thought of having long-term sexual relations with more than one sex partner is not disgusting to me.

I strongly agree: ____ : ____ : ____: ____ : ____: ____ : ____: I strongly disagree

THANK YOU.

Please move on to Questionnaire #3 on next page.

SOS-R-M Scoring Protocol (Fisher, White, et al., 1988, P. 127):

1. Score responses from 1 = I strongly agree to 7 = I strongly disagree

2. Add scores from items 2, 5, 6, 12, 13, 14, 15, 16, 19, and 20

3. Subtract from this total the sum of items 1, 3, 4, 7, 8, 9, 10, 11, 17, 18, and 21

4. Add 67 to this quantity

Scores range from 0 (most erotophobic) to 126 (most erotophilic)

Appendix GG

Demographic Survey - Online Version (Phase II)

Screening Questions

1.a. Registration in the College of Psychologists of your respective province/territory

- ○ No
- ○ Yes

b. If you answered 'Yes' above, identify the province/territory in which you are registered with a College of Psychologists. (please select only one)

- ☐ Alberta
- ☐ British Columbia
- ☐ Manitoba
- ☐ New Brunswick
- ☐ Newfoundland and Labrador
- ☐ Northwest Territories
- ☐ Nova Scotia
- ☐ Ontario
- ☐ Prince Edward Island
- ☐ Quebec
- ☐ Saskatchewan

c. Membership in the following

	Yes	No
Canadian Psychological Association (CPA)	○	○
Psychologists' Association of Alberta (PAA)	○	○
British Columbia Psychological Association (BCPA)	○	○
Manitoba Psychological Society (MPA)	○	○
Association of Psychology in Newfoundland Labrador (APNL)	○	○
Association of Psychologists of the Northwest Territories (APNWT)	○	○
Association of Psychologists of Nova Scotia (APNS)	○	○
Ontario Psychological Association (OPA)	○	○
Ontario Association of Psychological Associates (OAPA)	○	○
Psychological Association of Prince Edward Island (PAPEI)	○	○
Ordre des psychologues du Québec (OPQ)	○	○
Psychological Society of Saskatchewan (PSS)	○	○

2. Currently practicing

- ○ No
- ○ Yes

Questionnaire #3

3. Highest level of education completed (Please select only one)

- ○ Masters
- ○ Ph.D.
- ○ Psy.D.

4. Number of years in practice (please write the estimated number of years in the space below)

5. Population of Specialization (please select all that apply)

- ☐ Adults
- ☐ Couples
- ☐ Families
- ☐ Children
- ☐ Adolescents

Other (please specify)

6. Current workplace setting (please select all that apply)

- ☐ Hospital; Inpatient
- ☐ Hospital; Outpatient
- ☐ Correctional Facility
- ☐ Private Practice
- ☐ Non-profit Agency
- ☐ School
- ☐ Community Service Centre

Other (please specify)

7. Age in years (Please DO NOT provide your birthdate)

8. Gender

- Male
- Female
- Other (please specify)

9. Ethnicity (please select the ONE below that you feel best describes your ethnicity)

- Canadian
- American
- Aboriginal
- British Isles
- French Acadian
- French European
- Northern European
- Scandinavian
- Southern European
- Eastern European
- Baltic
- Czech and Slovak
- Western European
- Other European
- African
- Middle-Eastern/ Arab
- Maghrebi
- South Asian
- East and Southeast Asian
- West Asian
- Oceania
- Pacific Islands
- Latin, Central & South American
- Bi-racial
- Multi-racial
- Other (please specify)

10. Number of years lived in Canada

11. Current relationship status (please check only one)

- Married
- Common-Law
- Casually Dating
- In a Monogamous Relationship
- Separated
- Widowed
- Divorced
- Single
- Other (please specify)

12. Sexual orientation

	1 (Heterosexual)	2	3	4	5	6	7 (Homosexual)
sexual orientation	○	○	○	○	○	○	○

13. Comfort with using a COMPUTER

	1 (Extremely Uncomfortable)	2	3	4	5 (Extremely Comfortable)
Comfort level	○	○	○	○	○

14. Comfort with using the INTERNET

	1 (Extremely Uncomfortable)	2	3	4	5 (Extremely Comfortable)
Comfort level	○	○	○	○	○

15. Number of hours per week you use the COMPUTER for:
(it may help to use the last 2 weeks as a reference)

	0	1 - 5	6 - 10	11 - 20	21 - 30	31 - 40	41 - 50	more than 50
Personal purposes	○	○	○	○	○	○	○	○
Professional purposes	○	○	○	○	○	○	○	○

16. Number of hours per week you use the INTERNET for:
(it may help to use the last 2 weeks as a reference)

	0	1 - 5	6 - 10	11 - 20	21 - 30	31 - 40	41 - 50	more than 50
Personal purposes	○	○	○	○	○	○	○	○
Professional purposes	○	○	○	○	○	○	○	○

17. Purposes for which you generally use the COMPUTER (please check all that apply)

- Creating or editing documents
- Creating or editing spreadsheets
- Emailing
- Calendar management
- Arranging meetings
- Creating/managing To-Do lists
- Creating presentations
- Photo storage
- Photo editing
- Image creating
- Image editing
- Reading journal articles
- Data analysis
- Video conferencing
- Searching the Internet
- Computer games
- Reading CD-ROMs
- Playing DVDs
- Organizing files/folders
- Video storage
- Video editing
- Website design
- Software programming
- N/A: I have never used a computer
- Other (please specify)

18. Purposes for which you generally use the INTERNET(please check all that apply)

- Entertainment
- Online computer games
- Emailing
- Calendar management
- Shopping
- Professional work
- Travel planning and/or booking
- Photo storage
- Photo editing
- Image editing
- Researching journal articles
- Downloading journal articles
- Web conferencing
- General Browsing
- Chat sites
- Interactive on-line games
- Searching for people/places
- Blogging
- Photo sharing
- Video editing
- Website creation (for self/others)
- MSN
- ICQ
- Skype
- Twitter
- Facebook
- My Space
- Instant Messaging (IM)
- Banking
- N/A: I have never used the Internet
- Other (please specify)

19. Amount of training you have received in each of these areas of psychology (using the below scale place the number that represents your amount of training received in the box next to each of the areas indicated)

(No Training At All) 0 ----------> 6 (Extensive Training)

	Amount of Trainining Received
Personality Disorders	
Substance Abuse	
Disaster Relief Psychology	
Drug Addiction	
Process Addictions	
Schizophrenia	
Anxiety Disorders	
Forensic Psychology	
Borderline Personality Disorder	
Dialectical-Behaviour Therapy	
Narrative Therapy	
Eating Disorders	
Sleep Disorders	
Bipolar Disorders	
Pathological Gambling	
Internet Addiction	
Alcohol Addiction	
Post-Traumatic Stress Disorder	
User-Interface Psychology	
Military Psychology	
Geriatric Psychology (Geropsychology)	
Obsessive Compulsive Disorders	
Attachment Disorders	
Cognitive-Behavior Therapy	
Aviation Psychology	
Mood Disorders	
Emotion-Regulation	
Dance Therapy	
Music Therapy	
Psychodrama	
Sex/Cybersex Addiction	
Veteran Affairs	
Industrial/Organizational Psychology	
Positive Psychology	
Psychotic Disorders	
International Psychology	
Environmental/ Conservation Psychology	

Other (please specify each additional area on a seperate line and indicate for each area added the amount of training in brackets using the above 0-6 scale)

Appendix HH

Demographic Survey - Mailed Version (Phase II)

SCREENING QUESTIONS

Please answer the following questions first by placing a check mark in the appropriate box.

1. a. Registration in the College of Psychologists of your respective province/territory

Yes ☐ No ☐

b. If you answered 'Yes' above, identify the province/territory in which you are registered with a College of Psychologists. (please select only one)

Alberta ☐	Newfoundland and Labrador ☐	Prince Edward Island ☐
British Columbia ☐	North West Territories ☐	Quebec ☐
Manitoba ☐	Nova Scotia ☐	Saskatchewan ☐
New Brunswick ☐	Ontario ☐	

2. Currently practicing

Yes ☐ No ☐

*__**IF YOU ANSWERED NO TO EITHER** QUESTIONS #1(a) OR #2 ABOVE__

- Please do not complete this research.
- Thank you for your willingness to participate.

*__**IF YOU ANSWERED YES TO BOTH** QUESTIONS #1(a) AND #2 ABOVE__

- Please proceed to the next page of questions.

QUESTIONNAIRE #3
(continued from Screening Questions)

Instructions: Please respond to each of the following items.

3. Highest level of education completed (please check only one)

Masters ☐ Ph.D. ☐ Psy.D. ☐

4. Number of years in practice (please write the estimated number of years in the space below)

_____ years

5. Population of Specialization (please check all that apply)

Adults ☐ Families ☐ Adolescents ☐
Couples ☐ Children ☐ _____ Other ☐

6. Current workplace setting (please check all that apply)

Hospital; Inpatient ☐ Private practice ☐ Community Service Centre ☐
Hospital; Outpatient ☐ Non-profit Agency ☐ _____ Other ☐
Correctional Facility ☐ School ☐

7. Age in years (Please DO NOT provide your birthdate)

_____ years

8. Gender (please check one)

Male ☐ Female ☐ _____ Other ☐

continued on next page…

9. Ethnicity (please select the ONE below that you feel best describes your ethnicity)

Canadian ☐	Eastern European ☐	East and Southeast Asian ☐
American ☐	Baltic ☐	West Asian ☐
Aboriginal ☐	Czech and Slovak ☐	Oceania ☐
British Isles ☐	Western European ☐	Pacific Islands ☐
French Acadian ☐	Other European ☐	Latin, Central & South American ☐
French European ☐	African ☐	Bi-racial ☐
Northern European ☐	Middle-Eastern/ Arab ☐	Multi-racial ☐
Scandinavian ☐	Maghrebi ☐	_____ Other ☐
Southern European ☐	South Asian ☐	

10. Number of years lived in Canada _____ years

11. Current relationship status (please check only one)

Married ☐	Separated ☐
Common-Law ☐	Widowed ☐
Casually Dating ☐	Divorced ☐
In a Monogamous Relationship ☐	Single ☐
	_____ Other ☐

12. Sexual orientation (please check only one from the range indicated below)

	1	**2**	**3**	**4**	**5**	**6**	**7**	
Heterosexual	☐	☐	☐	☐	☐	☐	☐	*Homosexual*

continued on next page…

13. Comfort with using a COMPUTER (please check only one from the range indicated below)

	1	**2**	**3**	**4**	**5**	
Extremely Uncomfortable	☐	☐	☐	☐	☐	*Extremely Comfortable*

14. Comfort with using the INTERNET (please check only one from the range indicated below)

	1	**2**	**3**	**4**	**5**	
Extremely Uncomfortable	☐	☐	☐	☐	☐	*Extremely Comfortable*

15. Number of hours per week you use the COMPUTER for:

(it may help to use the last 2 weeks as a reference – please check off only one in each of the personal and professional categories below)

	0	1 - 5	6 - 10	11 - 20	21 – 30	31 – 40	41 – 50	more than 50
Personal purposes	☐	☐	☐	☐	☐	☐	☐	☐
Professional purposes	☐	☐	☐	☐	☐	☐	☐	☐

16. Number of hours per week you use the INTERNET for:

(it may help to use the last 2 weeks as a reference – please check off only one in each of the personal and professional categories below)

	0	1 - 5	6 - 10	11 - 20	21 – 30	31 – 40	41 – 50	more than 50
Personal purposes	☐	☐	☐	☐	☐	☐	☐	☐
Professional purposes	☐	☐	☐	☐	☐	☐	☐	☐

continued on next page…

17. Purposes for which you generally use the COMPUTER (please check ALL that apply)

Creating or editing documents ☐	Image creating ☐	Organizing files/folders ☐
Creating or editing spreadsheets ☐	Image editing ☐	Video storage ☐
Emailing ☐	Reading journal articles ☐	Video editing ☐
Calendar management ☐	Data analysis ☐	Website design ☐
Arranging meetings ☐	Video conferencing ☐	Software programming ☐
Creating/managing To-Do lists ☐	Searching the Internet ☐	N/A: I have never used a computer ☐
Creating presentations ☐	Computer games ☐	_____ Other ☐
Photo storage ☐	Reading CD-ROMs ☐	_____ Other ☐
Photo editing ☐	Playing DVDs ☐	_____ Other ☐

18. Purposes for which you generally use the INTERNET (please check ALL that apply)

Entertainment ☐	Researching journal articles ☐	MSN ☐
Online computer games ☐	Downloading journal articles ☐	ICQ ☐
Emailing ☐	Web conferencing ☐	Skype ☐
Calendar management ☐	General Browsing ☐	Twitter ☐
Shopping ☐	Chat sites ☐	Facebook ☐
Professional work ☐	Interactive on-line games ☐	My Space ☐
Travel planning &/or booking ☐	Searching for people/places ☐	Instant Messaging (IM) ☐
Photo storage ☐	Blogging ☐	Banking ☐
Photo editing ☐	Photo sharing ☐	N/A: I have never used the Internet ☐
Image editing ☐	Video editing ☐	_____ Other ☐
	Website creation (for self/others) ☐	

continued on next page…

19. Amount of training you have received in EACH of these areas of psychology

(using the below scale place the number that represents your amount of training received in the box <u>next to each</u> of the areas indicated)

No Training At All **0** ⟷ **6** ***Extensive Training***

Personality Disorders		Geriatric Psychology (Geropsychology)	
Substance Abuse		Obsessive Compulsive Disorders	
Disaster Relief Psychology		Attachment Disorders	
Drug Addiction		Cognitive-Behavior Therapy	
Process Addictions		Aviation Psychology	
Schizophrenia		Mood Disorders	
Anxiety Disorders		Emotion-Regulation	
Forensic Psychology		Dance Therapy	
Borderline Personality Disorder		Music Therapy	
Dialectical-Behaviour Therapy		Psychodrama	
Narrative Therapy		Sex/Cybersex Addiction	
Eating Disorders		Veteran Affairs	
Sleep Disorders		Industrial/Organizational Psychology	
Bipolar Disorders		Positive Psychology	
Pathological Gambling		Psychotic Disorders	
Internet Addiction		International Psychology	
Alcohol Addiction		Environmental/ Conservation Psychology	
Post-Traumatic Stress Disorder		_____ Other	
User-Interface Psychology		_____ Other	
Military Psychology			

THE END.

THANK YOU FOR YOUR PARTICIPATION.

Please insert your completed surveys in the enclosed postage-paid envelope.

Appendix II

Online Consent Form (Phase II)

STUDY ABOUT THE ROLE OF THERAPISTS' CHARACTERISTICS IN THEIR PERCEPTIONS OF CLIENTS' PRESENTING PROBLEMS

Principal Investigator: Easter Yassa, M.A.
Purpose of the research: fulfillment of dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta, Edmonton, Alberta.

Consent Form

I ask that you read this form before agreeing to participate in this study.

Description of the research

You are invited to participate in a study to examine if there is a relationship between therapists' characteristics and their perceptions of the presenting problems of their clients. There are no right or wrong answers on the following surveys and this is not a test.

You are invited to visit click here starting on July 1, 2010 for a full explanation of this study. This website will be available for a period of one month after its posting.

What will my participation involve?

If you decide to participate in this research, consent will be given upon your commencement of the study. You will be asked to complete 3 questionnaires, which will include;

- personal and professional demographic questions
- questions about your sexual attitudes
- 3 written client vignettes and subsequent questions about what you think the issue is for the client represented in the vignette

Your participation will last approximately 25 – 35 minutes. If you have already received a mailed package regarding this study, you can complete these questionnaires by paper and then return them in the stamped return-addressed envelope that was in the package. If you have not received this mailed package or, if you prefer, an online version of the questionnaires is also available for your convenience by clicking continue at the bottom of this consent form. If you complete the surveys online you must do so in one sitting as exiting the online survey will cause all your data to be lost.

How will my confidentiality be protected?

All the data enclosed in this study will be anonymous and coded and will not be identified with you personally in any way. The anonymous ID which you will be prompted to create is used only to keep your surveys together without identifying who you are. All surveys, when returned will be kept secure and confidential even though they will contain no identifying information.

Are there any risks to me?

I don't anticipate any risks to you from your participation in this research, however, some of the questions are of a sexual nature and some people may feel some mild discomfort in reading and responding to them. You are of course free to choose not to participate in this research at no consequence to yourself.

Are there any benefits to me?

The benefits of participation, however, are significant and include the knowledge that you have contributed something valuable to the knowledge base of your profession and have assisted indirectly in helping other therapists (including graduate students and seasoned professionals) learn about their role in the therapeutic assessment process.

What are my rights as a participant?

As a participant you have several rights you should be aware of. You have the right to;

- Not participate
- Privacy, anonymity and confidentiality
- Safeguards for the security of data and when appropriate (after a minimum of 5 years) the appropriate methods for the destruction of data that ensures your continued privacy and confidentiality
- Disclosure regarding the presence of any apparent or actual conflict of interest on the part of the researcher
- A copy of the report of the research findings when it is completed by advising the researcher via mail, email or telephone.

If I want to withdraw my participation after I have submitted the surveys, can I?

Unfortunately, no. Once you submit your completed surveys withdrawal of your specific data will not be possible given that the surveys are anonymous and no information will be kept linking your anonymous survey to your identifying information.

What do you plan to do with the data?

On completion of this study I intend to publish the findings making them accessible for all who are interested.

Who do I contact if I have any questions?

If you have any questions about your rights as a research subject, you should contact the principal investigator, Easter Yassa, at eyassa@ualberta.ca or via mail at: Easter Yassa, Department of Educational Psychology, 6-102 Education North, University of Alberta, Edmonton, AB, T6G 2G5. You may also contact the University of Alberta, Department of Educational Psychology at 780- 492-5245 if you have any questions or comments regarding the research.

Remember your participation is completely voluntary. If you begin filling out the survey(s) and change your mind at any time, you may end your participation without penalty by either not returning the paper surveys or, if choosing to complete them online, simply closing the browser window.

Thank you.

Sincerely,

Easter Yassa, M.A., Ph.D. Student, Counselling Psychology
Department of Education, University of Alberta
Tel: 780- 504-3363; Email: eyassa@ualberta.ca

Please Note: The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at 780-492-3751.

By clicking on the continue button below you are agreeing to the following;

- I am at least 18 years of age and have read and understood the above information, and
- I consent to voluntarily participate in this study
- In understand that once I submit my completed surveys I will not be able to withdraw my data as the surveys are anonymous and cannot be linked with my identifying information

CONTINUE

EXIT

Next >>

Appendix JJ

Mailed Consent Form (Phase II)

STUDY ABOUT THE ROLE OF THERAPISTS' CHARACTERISTICS IN THEIR PERCEPTIONS OF CLIENTS' PRESENTING PROBLEMS

Principal Investigator: Easter Yassa, M.A.
Purpose of the research: fulfillment of dissertation requirements for a Ph.D. in Counselling Psychology at the University of Alberta, Edmonton, Alberta.

Consent Form

I ask that you read this form before agreeing to participate in this study.

Description of the research

You are invited to participate in a study to examine if there is a relationship between therapists' characteristics and their perceptions of the presenting problems of their clients. There are no right or wrong answers on the following surveys and this is not a test.

You are invited to visit www.surveymonkey.com/s/debrieftherapistscharacteristicsphdresearch starting on July 1, 2010 for a full explanation of this study. This website will be available for a period of one month after its posting.

What will my participation involve?

If you decide to participate in this research, consent will be given upon your commencement of the study. You will be asked to complete 3 questionnaires, which will include;

- personal and professional demographic questions
- questions about your sexual attitudes
- 3 written client vignettes and subsequent questions about what you think the issue is for the client represented in the vignette

Your participation will last approximately 30 – 35 minutes. You can complete these questionnaires by paper and then return them in the stamped return-addressed envelope that was also in the package you received. For your convenience an online version of the questionnaires are also available at: www.surveymonkey.com/s/therapistscharacteristicsphdresearch1

How will my confidentiality be protected?

All the data enclosed in this study will be anonymous and coded and will not be identified with you personally in any way. The anonymous ID which you will be prompted to create is used only to keep your surveys together without identifying who you are. All surveys, when returned will be kept secure and confidential even though they will contain no identifying information.

Are there any risks to me?

I don't anticipate any risks to you from your participation in this research, however, some of the questions are of a sexual nature and some people may feel some mild discomfort in reading and responding to them. You are of course free to choose not to participate in this research at no consequence to yourself.

Are there any benefits to me?

The benefits of participation, however, are significant and include the knowledge that you have contributed something valuable to the knowledge base of your profession and have assisted indirectly in helping other therapists (including graduate students and seasoned professionals) learn about their role in the therapeutic assessment process.

Please turn page over to continue…

What are my rights as a participant?

As a participant you have several rights you should be aware of. You have the right to;

- Not participate
- Privacy, anonymity and confidentiality
- Safeguards for the security of data and when appropriate (after a minimum of 5 years) the appropriate methods for the destruction of data that ensures your continued privacy and confidentiality
- Disclosure regarding the presence of any apparent or actual conflict of interest on the part of the researcher
- A copy of the report of the research findings when it is completed by advising the researcher via mail, email or telephone.

If I want to withdraw my participation after I have submitted the surveys, can I?

Unfortunately, no. Once you submit your completed surveys withdrawal of your specific data will not be possible given that the surveys are anonymous and no information will be kept linking your anonymous survey to your identifying information.

What do you plan to do with the data?

On completion of this study I intend to publish the findings making them accessible for all who are interested.

Who do I contact if I have any questions?

If you have any questions about your rights as a research subject, you should contact the principal investigator, Easter Yassa, at eyassa@ualberta.ca or via mail at: Easter Yassa, Department of Educational Psychology, 6-102 Education North, University of Alberta, Edmonton, AB, T6G 2G5. You may also contact the University of Alberta, Department of Educational Psychology at 780- 492-5245 if you have any questions or comments regarding the research.

Remember your participation is completely voluntary. If you begin filling out the survey(s) and change your mind at any time, you may end your participation without penalty by either not returning the surveys or, if online, simply closing the browser window.

By completing and mailing back the surveys you are agreeing to the following;

- I am at least 18 years of age and have read and understood the above information, and
- I consent to voluntarily participate in this study
- In understand that once I submit my completed surveys I will not be able to withdraw my data as the surveys are anonymous and cannot be linked with my identifying information

Thank you.

Sincerely,

Easter Yassa, MA, Ph.D. Student, Counselling Psychology

Department of Education, University of Alberta

Tel: 780- 504-3363; Email: eyassa@ualberta.ca

Please Note: The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at 780-492-3751.

Appendix KK

PAA Mailed Survey Package - Cover Page Anonymous ID (Phase II)

<u>These questionnaires are completely Anonymous.</u>

Before beginning, please create your Anonymous ID using the instructions below and enter it into the space provided.

This facilitates data entry only and does not in any way allow you to be identified.

Your Anonymous ID#: ____- ____- ____- ____
1 2 3 4

PLEASE KEEP ALL PAGES OF THE SURVEY PAGES STAPLED TOGETHER WITH THIS PAGE WHEN YOU RETURN THEM.

To create your Anonymous ID above, please use the following process;

- The 1st digit is the 1st letter of your middle name (if no middle name, write "Z")
- The 2nd digit is the 1st letter of the month in which you were born
- The 3rd digit is the 1st letter of your mother's first name (if unknown, write "Y")
- The 4th digit is the 1st letter of your father's first name (if unknown, write "X")
