Treating Those Who Struggle with Their Sexual Desires

David J. Ley, Ph.D.

Introduction

As an advocate for treatment utilizing an evidence based, non-shaming model of sexual health, I invite mindfulness, caution and self-examination in clinicians who are asked to treat people who report struggles to control their sexual behaviors. For many years, treatment of these types of issues has largely been the purview of the sex addiction industry. Unfortunately, the treatment theories and approaches employed in the sex addiction model are rooted in a view of sex, which is contrary to the sexual health principles endorsed by sex therapists.

In response to the inherent conflict between the principles of a sexual health model and the approaches of the modern sex addiction treatment industry, the American Association of Sexuality Educators, Counselors and Therapists (AASECT) took the historic step in 2016 to issue a position statement rejecting the construct of sex addiction in sexual therapy (AASECT, 2016). In it, they identified an over-arching desire to avoid pathologizing consensual sexuality, described a lack of support for sex addiction as a mental health disorder, and found that training in sex addiction was not adequately informed by accurate knowledge of human sexuality.

Clinicians hold tremendous responsibility as we render diagnoses and recommend treatment. Ethical and therapeutic diagnosis and treatment requires that we be aware of the risks and limitations of our knowledge. When it comes to sexual issues, unfortunately, the field of medicine and mental health have a long, tragic history of allowing moral and social biases to intrude upon clinical judgment and treatment. Women were diagnosed as nymphomaniacs and subjected to invasive, non-consensual and life-altering treatments, in many cases merely for

admitting that they liked and wanted sex (Groneman, 2000). In the first edition of the American Psychiatric Association's Diagnostic and Statistical Manual, masturbation itself was diagnosable as a mental illness, under the code 317.1 (APA, 1952, p. 97). Healthcare is susceptible to influence by social and moral sexual concerns, and that influence can and has resulted in malpractice and harm to innocents. We are ethically compelled to exercise extreme caution as we diagnose and treat issues that present as sexual behavior problems, understanding their history and context, and modifying our approaches based upon new data. To ethically support patients, it is critical that our treatment of sexual behavior problems be grounded in a foundation of sexual health, rooted in an affirmative model, and address individuals in a holistic, comprehensive manner.

Historical Context of Sex Addiction

The concept of sex addiction was introduced into the modern lexicon in the late 1970s and 1980s. Early proponents of the concept framed homosexuality itself as an addiction, and the sex addiction movement has a long history of describing non-monogamous and non-heteronormative sexual behaviors as pathological (Reay, Attwood & Gooder, 2015). The AIDS crisis of the early 1980s contributed to significant changes in the perception of male homosexuality, bisexuality, and sexual promiscuity. Countless gay and bisexual men reacted to the AIDS crisis by perceiving their struggles to exert control over their sexual desires as a disease. These men identified as sex addicts, and some even became sex addiction therapists, as ways to try to increase control over their socially-condemned sexual desires, and to share this method with others (Kort, 2015). In a current, very large, nonclinical sample, LGBTQ individuals were the largest group identified as "at risk" for diagnosis, using criteria based on the Hypersexual Disorder construct (Bothe, Bartok, et al., 2016). Hypersexual Disorder was a

proposed diagnosis in the Diagnostic and Statistical Manual (DSM)-5, but was ultimately rejected by the APA, due to concerns about risk of over diagnosis (Reid & Kafka, 2014). Throughout the sex addiction clinical literature, gay and bisexual sexualities are commonly identified as problematic. Expectations of monogamy, and condemnations of casual sex underlie clinical judgments of sexual practices, which are, in many cases, part of LGBTQ culture and communities, with no clear evidence that these practices are indeed harmful.

What is commonly called sex addiction is a label without explanatory power applied to a heterogeneous group of people and problems (Cantor, et al, 2013). There are countless terms applied to this behavior, including sex addiction, sexual impulsivity/compulsivity, hypersexual disorder, nymphomania, satyriasis (excessive or abnormal sexual desire in a man), erotomania (delusion of another person being infatuated with them). The field uses varying theories of etiology and diagnosis, each generating its own school of thought and approach. These terms and theories shift over time, largely in response to social shifts towards sexuality. These idiosyncratic approaches have inhibited evaluation of the underlying principles in these issues, and promote treatments for which there is no evidence of effectiveness in the area of sexual problems (e.g. Grubbs et al., 2015b; Reid, 2013).

This is a critical point for clinicians to understand. There is a dearth of evidence that treatment for sex addiction has a positive effect, diminishes problematic symptoms, improves quality of life or resolves relationship conflicts over sexuality. Traditional sex addiction treatment is almost entirely based upon concepts of 12-step group treatment, a model based largely upon religious concepts, not clinical ones. Recent work suggests that 12-step treatments may have a positive effect in fewer than 10% of people referred, and may potentially have a harmful effect in many people sent to such programs (Dodes & Dodes, 2014; Fletcher, 2013).

Sex addiction treatment programs and therapists often incorporate a variety of treatment and assessment methodologies, without an overarching theoretical framework. None of these treatments are clinically supported for such problems.

Clinicians frequently ask, "Well, what SHOULD we call it then?" I suggest that this search for a single label may be misleading. The terms used in this debate do matter, as the terms guide and define theories and interventions. Currently, terms such as "compulsive sexual behavior" (CSB) or "out of control sexual behavior" (OCSB) are growing in popularity, representing a rejection of the dominance of the sex addiction model. The term compulsive implies theory and etiology from anxiety disorders, where compulsions are behaviors engaged in to seek relief from intrusive thoughts and related anxiety. Unfortunately, without adequate distinction of compulsive sexual behaviour from compulsions in anxiety disorders, inappropriate and unsupported comparisons may be implied.

Out of control sexual behavior is the term suggested by Braun-Harvey and Vigorito (2016, p. 28), who acknowledge that what they are describing is the subjective feeling of being out of control, as opposed to behavior that is actually uncontrollable. The nuance of this distinction may be lost in layperson discussions, and terms such as under-controlled or diminished control might convey some of the missing elements of perception and choice (Reid, 2016). It is unlikely that any single term is ever going to be adequate or effective in describing such a wide range of heterogeneous behaviors with complex, interacting motivations and effects.

These sexual behaviour problems may be indicative of other problems, or may simply be symptoms of other issues. Numerous studies suggest that sex and pornography use are ways in which males attempt to cope with negative emotions (e.g. Wright, 2012). A 2016 European study of self-identified sex addicts found that 90% had a diagnosable psychiatric disorder, most

commonly mood or anxiety disorders, and that 60% had at least one diagnosable paraphilic disorder (Wery, et al., 2016). A common symptom of paraphilic disorders is extreme sexual preoccupation and high levels of sexual behaviors, focused on interests other than physical interaction with phenotypically normal, consenting and mature individuals. Unfortunately, this sexual preoccupation and drive may be mislabelled as sexual addiction, without clinical acknowledgment of the other sexual symptoms. In this chapter, I ultimately argue that it is the job of treating clinicians to conceptualize these behaviors at deeper, richer levels than a single term can capture. Sexuality is a heterogeneous, complex, highly over-determined behavior that includes a bewildering, ever-evolving range of experiences and desires. A clinical or diagnostic approach towards such varied phenomena must be equally complex. The effective and informed sexual health clinician approaches these issues in an individualized manner which identifies and addresses underlying mental health problems, sexual disorders, moral conflicts or relational conflicts, which are contributing to the current reports of sex-related problems. Sexual behaviour problems, which may lead to people seeking treatment, are best seen as symptoms of varied problems or conflicts, rather than the problem itself.

It is important to attend to the sometimes extreme consequences and risks attributed to sexual behaviour difficulties, ranging from exposure to sexually-transmitted infections, to spending large amounts of money. Unfortunately, while evidence grows about the numbers of people who feel distress over their sexual desires, there remains relatively little non-anecdotal data about the prevalence and severity of such consequences in this group, compared to the population at large. These findings suggest that, at this time, clinicians may be most effective by directing clinical interventions towards the distress associated with difficulty controlling sexual urges (Dickenson, Gleason, Coleman & Miner. 2018).

Researching Subjective Difficulties with Sexual Self-Control

Those reporting difficulties controlling their sexual behaviors do not appear to engage in more frequent sexual behaviors than others. Sex addicts are seen by others and by self-report as having executive function deficits in areas such as impulsivity and self-control, particularly in regards to their sexual behavior, though neuropsychological testing has revealed that sex addicts may demonstrate no measurable problems in impulse control or executive functioning, and laboratory research finds that sex addicts display no greater difficulty controlling their sexual arousal (Reid et al., 2011; Winters, Christoff & Gorzalka, 2010).

Numerous studies have provided evidence that multiple variables contribute to reports of problems with sexual self-control. Self-identification as addicted to pornography has been found to be predicted by moral conflict and religiosity and not by levels of pornography consumed (Grubbs et al., 2015a). Men labelled as hypersexual or sexually compulsive most often differ from other highly sexual but untroubled men, by being religious, not heterosexual, viewing pornography negatively and holding more negative attitudes about one's own sexuality. The frequency of sexual behaviors does not distinguish these men, from other non-disordered males (Štulhofer, Jurin & Briken, 2015). There is no causal evidence indicating that sexual behaviors result in neurological changes in the brain, as is seen in of the brain scans associated with substance use disorders, and pre-existing neurologically-influenced traits such as libido and sensation-seeking explain more of the variance in self-identified sex addicts' behavior (Prause et al., 2015; Steele et al., 2013).

The use of pornography, particularly via the Internet, has become a central focus of discussions of sexual self-control problems. The ease of access to this material on the Internet has been blamed for a rise in problematic use of pornography, though research suggests that

variables such as affordability, access and anonymity do not explain variations in use of this material (Byers, et al., 2004). There is a clinical and social assumption that pornography is intrinsically different, in content and effect, from other forms of media and that it has qualitatively and quantitatively unique effects. For instance, in studies which examine reports of problematic use of pornography, "extreme" use of pornography has often been quantified as daily use, and in one representative study, as a mere 17 minutes of pornography use a day, which is far less than average consumption of other media such as television (Wordecha et al., 2018).

A unique, clinically relevant element to pornography use is that it is accompanied by masturbation (Prause et al., 2015). Consumption of pornography typically ends when an individual achieves an orgasm, more so in males (LoPresti & McGloin, 2018). Thus, pornography use is best conceived of, as a tool to enhance or facilitate masturbation. Claims of effects of pornography use are better framed as effects of masturbation to pornography, and research finds that the links between pornography and relational happiness are best explained by variance in masturbation, not pornography (Perry, 2018). This leads to the recommendation that clinicians include a person's attitudes towards masturbation in their formulation of an individual's problems related to pornography.

Griffin, et al. (2016) found that when men view their sexual behavior and desires as incongruent with their morals, they are more likely to report under controlled problematic sexual behaviors. Grubbs, Perry, Wilt and Reid (2018) published a meta-analysis of pornography addiction research and concluded that the frequency of use of pornography itself does not predict problems with this medium, but that an individual's religiosity does. They suggest that Pornography Problems due to Moral Incongruence (PPMI) appear to be the driving force in many of the people who report dysregulated, uncontrollable, or problematic pornography use.

Religiousness was significantly predictive of the moral incongruence these individuals felt with their sexual behaviors, suggesting that religiosity and sexual moral conflicts are intrinsically linked. The stronger the moral conflict an individual felt over their sexual behaviors, the higher the level of difficulty they report feeling in attempts to control their sexual behaviors. Feeling "out of control" of one's sexual urges did not predict higher levels of sexual behavior or pornography consumption, but did contribute to greater feelings of distress over these desires and behaviors. Higher levels of moral conflict over ongoing pornography use predict higher levels of stress, anxiety, depression, diminished sexual well-being, as well as religious and spiritual struggles. In a separate study by Perry and Whitehead (2018), pornography use predicted depression over a period of six years, but only in men who morally disapproved of porn use.

Efrati (2018) found that attempts by religious individuals to suppress sexual thoughts actually led to an increase in these sexual thoughts. He suggested that when a religious individual attempts to suppress their sexuality in order to be virtuous, it might, paradoxically, increase the frequency and intensity of these sexual desires and thoughts. More religious individuals may exert more effort in their sexual suppression, thus furthering the intensity of this rebound effect. This spiralling problem may then result in feelings of dissatisfaction and dysphoria in life. Belief in God and higher levels of religiosity may increase the degree to which individuals perceive themselves as addicted to pornography, and seeing oneself as addicted to pornography predicts greater levels of anger, low self-esteem, and anger towards God (Wilt, et al. 2016).

Clinically, these varied findings suggest that instead of assessing sexual behaviors or pornography use in people who seek help for these issues, clinicians and therapists may be best served by first assessing a person's religiosity and their moral attitudes about sex, pornography and masturbation. In therapy, instead of trying to change people's porn use patterns, clinicians

may be more effective through increasing self-awareness of this moral conflict and helping patients to make their values and behavior congruent. Conflict between morality and sexual behavior may be resolved by changing one's sexual behavior *or* by changing one's values *or* simply by helping people become conscious and mindful of this internal conflict. Helping people to consciously examine and consider their religious beliefs about sex, masturbation and porn, with modern, adult, self-determining eyes, may help them reduce the pain and suffering caused by this moral conflict. It may be normal for people who are younger and struggling in life to also struggle with managing and accommodating their sexual desires. Rather than suppressing a person's sexuality, a sound clinical strategy may simply be to let time do its work, while the clinician focuses on assisting the patient in improving their life as a whole, developing and enhancing coping skills, personal resources and problem-solving strategies.

Simply assuming the validity of a patient's self-report that they "feel" that they cannot control their sexual behavior is not supported by research, and is not conducive to effective treatment. Braun-Harvey and Vigorito cleverly depict this, saying: "We often illustrate this dilemma with a medical parallel. A patient walks into his doctor's office and says "Doc, I have cancer." And the doctor says, "Well, at least we don't have to run all those tests. Let's start treatment." (p. 57) A Swedish study (Oberg, Hallberg, Kaldo, Dhejne, & Arve, 2017) found only 50% of a small sample of people who self-identified as having "hypersexual disorder" actually met the criteria which had been developed for this proposed diagnosis. Similarly, urologists have described that young males who present for treatment with the self-diagnosis of pornography addiction can be challenging patients, resistant to addressing underlying emotional issues or exploring alternative approaches recommended by the clinician (Reed-Maldonado & Lue, 2016). Unfortunately, disagreeing with the patients' self-diagnosis may result in treatment rejection and

patient's "shopping" for a clinician who will support their self-diagnosis. Clinical skepticism in these areas is valuable, so long as it is framed within a caring, empathic and supportive framework.

Compulsive Sexual Behavior Disorder in ICD-11

In 2018, working groups of the World Health Organization proposed inclusion of Compulsive Sexual Behavior Disorder (CSBD) in the 11th edition of the International Classification of Disease (Kraus, et al 2018). The ICD is the international coding manual, of diagnosis labels and associated diagnostic codes. ICD-10 includes a diagnosis of "Excessive Sexual Drive," code F52.7, which is subdivided into "Nymphomania" and "Satyriasis." Nymphomania and Satyriasis are antiquated terms no longer accepted as useful or valid diagnoses in most developed health systems, due in part to the long history of sexism and racism embedded in these constructs. Excessive Sexual Drive in ICD-10 does not give a benchmark for determining what is "excessive." The proposed CSBD diagnosis includes greater levels of detail, and is suggested for inclusion as an Impulse Control Disorder, not as an addiction. There is general professional agreement that there is not yet definitive information or data to support the notion that sexuality can be addictive, with similar processes to drugs. (APA 2013, p. 481; Kraus, et al., 2018).

In the CSBD diagnostic description, WHO effectively excluded a significant majority of those who self-diagnose or are in treatment with reports that they cannot control their sexual behaviors. By excluding those people struggling with primary moral conflicts; mood disorders; paraphilic disorders; adolescents, and those who self-identify as having problems due to sex but show no impaired control (such as individuals who self-identify as sexual addicts when their sexual behavior become public and result in scandal or

consequences) they've potentially ruled out many of the people currently seeking treatment as sex addicts. No research currently offers clarity as to the number or type of individuals who will still warrant this diagnosis after accurate application of these exclusions.

The WHO decision to adopt CSBD may have little impact in the United States, for many years to come. It is likely that the US won't adopt ICD-11 before 2025, without specific legislation (Berglund, 2018). As a result, the CSBD diagnosis will not be billable or formally diagnosable in the US healthcare system for many years, and additional research may further inform that decision. When countries do implement new editions of the ICD, they sometimes do so selectively. In Sweden and Finland, diagnostic codes for paraphilias such as Sadism or Masochism were excluded, based on concerns that the diagnoses were stigmatizing, and reflected moral judgments rather than medical ones (Nitschke, Mokros, Osterheider & Marshall, 2012).

Applications to Sex Therapy

Given this volume of information and research about the various complex issues, which underlie patients reporting (or being described as) feeling out of control of their sexual behavior and desires, treatment must be guided by a thorough and holistic assessment. Simply because an individual describes their sexual desires or behavior as uncontrollable, or blames personal or psychological problems on their sexuality, does not necessarily mean that we as clinicians should assume this self-diagnosis accurate nor render treatment based on this subjective self-report. Attempting to distill all of the above research and history into assessment guidelines, the sex therapist must complete a thorough evaluation, exploring religiosity, moral conflict, mental health, comorbid sexual disorders, sexual satisfaction, sexual orientation, medical history, and the social context of the reported sexual problems. Not all of these components will necessarily result in a clinical diagnosis.

As Braun-Harvey and Vigorito (2016) argue, clinicians must consider the possibility that patients sometime seek treatment for behaviors which are actually healthy, and are problematic only because of a conflict, either within the individual or their environment. It is not the role of healthcare to "fix" a condition or behavior, which is healthy. Sexuality is an overwhelmingly positive, beneficial and healthy human behavior. Sexual frequency is associated with a long list of health benefits, including improved cardiac and prostate function, improved relationship quality, increased life satisfaction, and even longevity. Even pornography use is associated with increased knowledge of sexual anatomy, increased sexual novelty within relationships, is experienced as overwhelmingly positive in subjective reports, and is even associated with decreased rates of sexual violence within societies. (see Whipple, 2007 for benefits of sexual expression.) The following research demonstrates personal and social benefits of pornography exposure to sex (Hesse & Pedersen, 2017; Diamond, 2009; Hald and Malamuth, 2008; Kohut, Baer and Watts, 2016; Ley, Prause, & Finn, 2016; McKee, 2007; Štulhofer, Busko & Landripet, 2010; Watson & Smith, 2012).

Clinicians faced with patients reporting problems related to sexuality, reports of problematic high-frequency sexual behavior, and subjective experiences of loss/lack of control of ones' sexual desires or behavior must then ask a core question: Why is a typically healthy behavior associated with problems in this specific individual? This forces the clinician to begin to approach these issues without an assumption of homogeneity, and with a curious, inquisitive, data-driven strategy in order to identify the underlying causes, conflicts and contextual elements which may explain this effect and thus guide treatment.

There are currently no well-normed, well-designed and well-researched assessment instruments that have reached a level of sufficient validity to formally recommend a

clinician adopt them in standard practice. Screening instruments commonly available online in this area may create more rigidity in a patient's self-diagnosis. In my clinical practice with such patients and self-reported problems, I have commonly employed, a variety of clinical instruments assessing issues such as: mood and depression; medical symptoms; sexual sensation seeking; personality characteristics; sexual attitudes and values, and sexual satisfaction. There are measures used in research, and available for free, which assess consequences related to sexual behaviors, and hypersexual behaviors, though these measures are limited by basis upon self-report by individuals who are currently experiencing distress. Any of these assessment strategies may be helpful in developing an intervention approach which seeks to increase a person's insight into their sexual conflicts, and which may decrease their feelings of sexual dyscontrol. These interventions must often include psychoeducational components around sexuality, consistent with the educational foundation of the sex therapy PLISSIT Model (Taylor & Davis, 2007).

Assisting in Resolving Sexual-Moral Conflicts

Religiosity is, according to extant research, the best predictor of a moral conflict over sexuality. Sadly, when people within religious communities seek help for their sexual concerns, they are often encouraged to suppress or "battle" their sexuality, or sent to treatments such as sex or porn addiction programs, where their sexual desires are portrayed as a form of sickness, and the concepts of sexual purity are idealized (Shermer Sellers, 2017). These approaches to sexual experiences and feelings may create a feedback loop of shame, guilt and self-hatred, which, at the least, exacerbate sexual difficulties, or at worst, are the true root of reports of sexual self-control difficulties.

Sexual shame is an internalized feeling that ones' sexuality and erotic desires are abnormal and disgusting, and results from interactions with ones' culture, relationships, and self-judgment (Clark, 2017). People can overcome sexual shame in their lives, without abandoning their religious values and beliefs. Schermer Sellers (2017) suggests ways to assist people develop a new sexual ethic, resolving moral conflicts over sexuality through intentionally developing alternative sexual values. She identifies the core need to help religious people create a new, self-determined moral framework for their sexuality, one that they choose and develop as adults, which focuses on intentionality, authenticity, consent, honesty and mutuality. This approach assists people struggling with sexual shame to overcome it, not by rejecting themselves, but instead, by deciding who and how they want to be sexual, from a place of information rather than ignorance. Offering sexual education about the range of human sexuality, sexual diversity, and acknowledging struggles that conservative religions have with sexuality in the world, are ways to empower people to begin making their own decisions about how to integrate their sexual selves, with their spiritual selves. It is only when a person accepts their sexuality as an aspect of themselves, and not something that is external to them, that a person can truly begin to heal from sexual shame. Then, and only then, can they evaluate their sexuality from a position that supports their own health, in a way that promotes healthy sexual values, in their lives, relationships, and even their soul.

It is factors involving moral incongruity or sexual satisfaction, not excessive sexual behavior itself, that contribute significantly to the experience of feeling that one's sexuality is out of control or problematic. Attending to these conflicts must become a central component of a treatment approach for reported difficulties with sexual self-control. An informed clinical approach to the subjective experiences of lack of control is to assist the patient in recognizing

that feeling out of control is not the same thing as *being* out of control (Klein, 2012). This then helps to begin separating the sexual behaviour from the feelings about the behavior, and to begin examining the origins and experiences of those feelings, which often directs back to underlying moral or religious conflicts.

Clinically, therapists can help people through application of mindfulness techniques, values sorting exercises, anxiety and mood treatment, motivational interviewing, education and moral exploration. The conflict here is not the sex itself, though sexual behaviors are often a distracting and tempting target. The problem is that people choose to explore or experience sexuality without ever exploring or resolving their negative moral feelings towards the sex they desire or enjoy. Many religious people simply haven't been prepared with language or ways to understand and explore this conflict, without encountering shame, condemnation or rejection.

Unfortunately, exploring this internal conflict can be difficult. In the experience of myself and many other therapists, many people may be reluctant to explore the idea that their sexual problems stem from a religious-sexual conflict. This resistance may lie in the patient themselves, or in their family, spouse or religious community. Unfortunately, like so many modern issues, the more contradicting evidence we present, the stronger a person's opposition may become. It is best framed as an invitation to a patient to explore and discuss how their sexual values can be consciously and mindfully applied to their understanding of their sexual expression.

Clinical Interventions for Subjective Self-Control Difficulties

As described throughout this chapter, there is a paucity of research examining the effectiveness of treatments for self-reported difficulties with sexual self-control. Effective healthcare treatments should ideally be guided and informed by evidence and research, and must adapt and change as information grows. This facilitates better outcomes, prevents potential

harms, increases the efficiency and cost-effectiveness of services, and is an ethical requirement of licensed practitioners. Unfortunately, this is an area where there has been extremely little research, due largely to the stigma associated with sexual problems, and with the previously unchallenged dominance of the sexual addiction model. However, with increased attention to the issues described in this chapter the focus of research is beginning to change.

Cognitive behavior therapies with individuals who are identified as hypersexual have shown some evidence for success (Hallberg, et al. 2017) Cognitive behavioral therapy, with its attention to harm reduction, reinforcement, planning, and cognitive distortions offers, in my opinion, some of the most hopeful interventions for addressing sexual problems, by assisting the individual in reframing this problem as a behaviour, as opposed to a character flaw. Challenging cognitive distortions around sexual behaviour offers opportunity to see the behaviors in different ways, and to create opportunities for change, in behaviour and attitudes

Acceptance and Commitment Therapy (ACT) (Hayes & Strosahl, 2004) and the strategies of Motivational Interviewing (Rollnick & Miller 1995) offer compelling approaches to help patients recognize the ways in which their distress is related to their struggles to control their inner lives, thoughts, feelings and desires. In these models, clinicians help patients acknowledge that their efforts to control a behavior may worsen their distress, and be less effective than enhancing commitment and motivation towards change. These approaches offer potential clinical value through their non-judgmental approach to the behavior, such as sex, and their strategies for acknowledging the complex values and motivations that underlie complex behavior.

The approaches above stand in sharp contrast to 12-Step groups, which utilize a core addiction model, based upon an assumption of disease and pathology, and was originally

designed to provide help to individuals struggling with drug and alcohol problems. This model has proliferated into a variety of non-substance related problems though no current research supports the effectiveness of 12-Step approaches for sexuality issues. 12-Step groups are inherently based on spirituality, and non-religious patients may find these groups uncomfortable. There are many different sexuality-focused 12-Step groups, and some have explicit heterosexual and monogamy-based expectations which LGBTQ patients may experience as shaming and harmful. Unfortunately, in many areas of the country, patients may not have access to different groups nor an ability to select ones with which they may encounter fewer difficulties. Clinicians may do well to educate patients about these issues to support informed choices.

There are increasing references in clinical literature to the use of psychotropic medications to treat sexual behavior problems (Efrati & Gola, 2018). These include the use of anti-depressants such as SSRI's or other centrally acting medications, which may sometimes help in in reducing urges to engage in sexual behavior. The cost/ benefit analysis of side effects will need to be discussed in treatment. Most of these medications are used "off-label" or not designed specifically for distressing sexual symptoms. When used to treat underlying disorders, they may be appropriate. Application of these pharmaceutical treatments, in the absence of a thorough assessment to identify the complex factors contributing to self-reported sexual control difficulties, is fraught with ethical and clinical concerns.

Case Descriptions

I find it effective to illustrate a nuanced, sexual health-informed approach through offering case examples. The below descriptions offer snapshots of the individualized, strengths-based strategy for which I advocate.

Jerry: Jerry was a 32 year-old male who came to me for treatment, self-identifying with concerns that he was addicted to porn. His wife suggested he seek treatment, as she was upset at him choosing to masturbate to porn, rather than have sex with her. This is, in fact, a common report and issue identified in much literature. However, this case involved many more factors, as opposed to just porn. For instance, further assessment identified that Jerry and his wife worked different shifts; Jerry during the day, and his wife at night. When his wife came home from work, interested in sex, Jerry was in bed, tired, needing sleep for the next day. They'd never communicated or negotiated about scheduling sex to accommodate their work schedule. Jerry and his wife were also distressed that he sometimes lost his erection during sex, though he shared he had no difficulties during masturbation to porn. This, clinically, led us to acknowledge a significant physical health issue: both Jerry and his wife were clinically obese. Missionary-style sex, his wife's preferred position, was extremely physically challenging for Jerry. Better nutrition, health and exercise, as well as permission and encouragement to explore other sexual positions which might accommodate their bodies, helped the couple to experience more pleasurable sex with decreased erectile concerns. Finally, I helped Jerry and his wife discuss how frequently each was interested in sex. While Jerry was interested in sex 3-4 times a week, his wife was interested in sex about twice a week. They negotiated a discussion, which they'd never had previously, which led to a mutual agreement about the frequency of sex and masturbation, leading ultimately to successful resolution of treatment.

Roger: Roger was 53 year-old male who was referred to me, having been diagnosed as a sex addict by his wife, two former therapists and their pastor. Roger had been married to his wife, his only marriage, since they were in their early twenties, having married in 1987, at a time

when both were afraid of contracting HIV, particularly Roger who had a history of same-sex behaviors. Throughout their marriage, Roger struggled with infidelity and control of his sexual behaviors. He'd been caught multiple times engaging in casual sex through personals ads, going to adult bookstores and engaging in unprotected sex with other males, and had recently lost his job, caught viewing pornography at work. Roger had very high levels of depression and sadness, feeling extraordinary levels of shame over his inability to control his sexual desires and had contemplated suicide on multiple occasions. During our first session, I asked Roger what kind of pornography he was caught watching, and he described that it was gay porn. In fact, all of the sexual behaviors reported by Roger, identified as evidence of his sex addiction, were with other men. With education and assistance, Roger identified in therapy that he was a bisexual male, who was, at this time in his life, more interested in sex with other men, than with women. But, Roger was not at all interested in a romantic relationship with other men, and was only interested in a loving, romantic connection with his wife. However, throughout their marriage, Roger's wife had shamed and punished him, whenever she became aware of him being interested in other men. Our therapy then shifted direction from his past treatments, from attempting to control or change Roger's behaviour, to helping him to acknowledge and accept his bisexuality, and to see his sexual thoughts towards males as a normal and healthy part of his identity. We used cognitive behavioural strategies to address Roger's depression, increasing his exercise, self-care and attention to the ways in which he thought about himself and his sexuality. As we did so, Roger gained increased feelings of self-control over these sexual thoughts and desires, as he accepted them, as opposed to attempting to suppress and eradicate them. Roger was still a person in a mixed-orientation marriage, faced with the contemplation of infidelity, attempting to negotiate a consensually non-monogamous relationship, or ending the marriage. These were complex,

challenging issues for him to wrestle with, which had gone unacknowledged due to a focus on controlling his sexual behaviors. In our last session, Roger described to me, "I used to pray to God to take away these sexual thoughts, and now I'm thanking Him, for making me a more complex person with the capacity for a greater, richer experience of life and love."

Adrian: Adrian was a 56 year-old male who sought treatment following approximately twelve years of attending sex addiction 12-step programs, as well as multiple treatment episodes in intensive outpatient treatment for sex addiction at programs in Los Angeles. Adrian sought treatment from me, describing that despite many years of sex addiction treatment, he didn't feel it was working and he was still struggling with his sexual behaviors. Adrian saw me "in secret" from his wife, because he worried that if she searched my name, she would learn of my opposition to the concept of sex addiction, a concept that she very strongly embraced. Adrian was a financial/banking executive, married for 25 years with no children. Starting around 15 years ago, he began secretly visiting massage parlors where he engaged in sexual encounters, and also engaged in multiple affairs. He had a history of several sexually transmitted infections, at least one of which he had also passed to his wife. Each time these behaviors were revealed, he returned to sex addiction treatment, largely to appease his wife and maintain his marriage. In therapy, he described that he did not feel he was addicted to sex, though he used that language in treatment and in groups, in order to avoid being labelled as "resistant." During treatment, we focused on identifying the varied functions and rewards of these sexual behaviors. Adrian felt significant insecurity about his wealth, and felt more comfortable in lower economic settings, which were more consistent with his upbringing in poverty. Similarly, he felt insecure with his wife, threatened by her wealthier upbringing, education and status. Though he had a high libido and interest in sex, sex with his wife had decreased significantly over the past ten years, with the

couple averaging sex about once a month. He felt unable to confront or argue with his wife, but felt more power over her, when he engaged in secret infidelities. Adrian had no hobbies, and few areas in his life where he took care of himself, or allowed himself to feel rewarded. Treatment focused on helping Adrian to increase self-care activities other than sexuality, as well as education and role-play to help him practice communication with his wife. The couple was referred to marital therapy, but his wife refused, perceiving these issues as solely Adrian's problems. In therapy, Adrian discussed divorce, but decided that he was unwilling to lose his wife and their marriage. We then explored ways in which he could express his anger and feelings of powerlessness in a manner other than risking his own health and physical safety. Adrian was surprised, and confronted me once in therapy, "Aren't you supposed to make me stop cheating on my wife?" he asked. "I wasn't aware that infidelity was a mental disease, " I replied. "The job of therapy is to help you have the resources and skills to make the best decisions, for you. I think there are ways you CAN make better decisions, but it's not my job to tell you what those decisions should be." Though he continued to visit massage parlors about once a month, he began taking and using condoms, and acknowledged that his choice to seek these encounters was intentional and volitional. On one occasion, towards the end of our treatment, Adrian reported that he had recently gone to a massage parlor, but before getting out of his car, had "gone through my inventory," reviewing all the various emotional functions of these experiences, and "checked in" with himself. Adrian laughed that he spent so much time on this process, that he ran out of time to go into the establishment, but that he had realized he felt okay with himself at that moment, if he did or didn't complete the behavior. Adrian and his wife moved shortly thereafter, as he took a promotion to a higher position in a northeast city. He requested a referral to a new therapist, one who also didn't subscribe to the addiction model.

Carlos: Carlos, a 31 year-old male, referred for treatment while on probation for numerous drug-related criminal charges, mostly involving methamphetamine. Carlos was a gay male and disclosed that he was HIV positive, though he was currently on retroviral treatment. During assessment, Carlos self-described as a sex and porn addict, reporting that he didn't feel he could control his sexual behaviors. During intake, he was diagnosed with borderline personality disorder and substance use disorder. Carlos was first referred into substance use intensive outpatient treatment, but after numerous instances in group therapy where he engaged in unprovoked verbal attacks on other patients and instigated arguments, he was referred to individual therapy. In therapy with me, Carlos admitted that he enjoyed stirring everyone up, "so they feel like I do." Carlos was living in a sober group home, and wanted to focus in therapy on ways in which he felt he'd been mistreated by fellow residents, who were angry at him for engaging in disruptive an manipulative behaviors. Carlos shared that when there was "drama around, it makes me feel like when I am high." Carlos disclosed that, when high, he often engaged in unprotected sex with partners who were unaware of his HIV status, but simply said "they know the risks." In therapy, Carlos was extremely animated, delighted to recount tales of the interpersonal conflicts that swirled around him. Though Carlos initially agreed in therapy to attempt to work on reducing this "drama," in order to pursue healthier relationships and sexuality, he became angry when therapy focused on behavioural interventions to address these conflicts, as opposed to reinforcement of his emotional reactions. Carlos was ejected from his group home, due to a physical conflict with another resident. In therapy afterwards, he acknowledged that he had provoked the fight, because he had been bored and irritated with housemates, but that he didn't feel he deserved to be ejected. Eventually, after several such episodes, Carlos was discharged unsuccessfully from treatment, and referred for treatment for

borderline personality, though he refused to attend this treatment. This case illustrates what certainly some might call sex addiction. Nonetheless, his also demonstrated the need to always stir up drama based on his borderline personality disorder and substance abuse. His rejection of treatment for these problems would lead to a poor diagnosis and simply saying he was a sex addict was more acceptable than dealing with the deeper issues.

Conclusion

It is critically important to recognize that healthcare, including mental health and sex therapy treatment, can do great harm when we allow treatment to be based on morality rather than science. The historical approach to what has been defined by self or others as uncontrollable sexual behavior represents the intrusion of moral judgment and lack of sexually informed approaches. Self-report of difficulties with control of sexual behaviour should not be taken at face value. The report of sexual dyscontrol is not equivalent to objective evidence of impaired sexual self-control. Accepting a patient's statement that their behavior is uncontrollable, and joining with the patient to suppress their sexual behaviors, could create social and personal harm, without adequate evidence that these harms are counterbalanced by personal or social benefit. Though there can be significant personal and health risks to uncontrolled sexual behaviors, it appears at this time that effective interventions to reduce these risks involves treating underlying mental health disorder, substance use disorders and addressing unresolved moral and relational conflicts.

Subjective report of sexual self-control difficulties is clinically important, insofar as the clinician utilizes this disclosure to guide further inquiry. Many individuals with varied causes, etiologies, motivations and sexual behaviors, may identify sexual dyscontrol in treatment. This complex heterogeneity is critical to address and conceptualize, in order to most effectively and

ethically approach these matters. Treatment and diagnostic approaches that do not consider the complexity and diversity of sexuality run the risk of inadvertent pathologization, and may perpetuate cycles of sexual shame. Sexual shame, arising from unaddressed moral conflicts between religious sexual prohibitions and sexual desires, contributes greatly to perceptions of sexual self-control difficulties, and interferes with behavioral change. Similarly, self-control difficulties may emerge from other problems involving relational sexual satisfaction, psychological, medical or sexual disorders. Sexual self-control problems are best perceived as symptomatic of underlying conflicts and the effective sex therapist works to assist patients in understanding, recognizing and addressing these conflicts.

References

AASECT (2016). AASECT Position on Sex Addiction. At: https://www.aasect.org/position-sex-addiction Accessed December 12, 2018.

American Psychiatric Association (1952). *Diagnostic and Statistical Manual: Mental Disorders*. American Psychiatric Association Mental Hospital Services, Washington DC.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual: Mental Disorders* 5th Edition. American Psychiatric Association Publishing, Washington DC.

Associated Press (2004). Advocates want congress to study 'porn addiction.' November 19, 2004. At: https://www.foxnews.com/story/advocates-want-congress-to-study-porn-addiction Accessed December 12, 2018.

Bacardi, F. (2017). Ozzy Osbourne Backtracks on Sex Addiction Admission: "I Just Got Caught, Didn't I?" ENews, January 29, 2017. At: https://www.eonline.com/news/825102/ozzy-osbourne-backtracks-on-sex-addiction-admission-i-just-got-caught-didn-t-i Accessed December 9, 2018.

Berglund, D. (2018) Personal communication via email, July 19, 2018. David Berglund, MD, MPH, Medical Officer / Classification and Public Health Data Standards National Center for Health Statistics, Mailstop P08 Metro IV, 2nd floor, Rm. 2534, 3311 Toledo Rd. Hyattsville, MD 20782

Braun-Harvey, D., & Vigorito, M. (2016). *Treating Out of Control Sexual Behavior: Rethinking Sex Addiction.* Springer Publishing Company, New York.

Byers, L. J, Menzies, K. S. & O'Grady, W. L. (2004). The impact of computer variables on the viewing and sending of sexually explicit material on the internet: Testing Cooper's "Triple-A Engine." *The Canadian Journal of Human Sexuality, 13,* 3-4, 157-169.

Cantor, J. M., Klein, C., Lykins, A., Rullo, J. E., Thaler, L, & Walling, B. R. (2013). A treatment-oriented typology of self-identified hypersexuality referrals. *Archives of Sexual Behavior 42*, 5, 883-93. doi: 10.1007/s10508-013-0085-1

Clark, N. (2017). The etiology and phenomenology of sexual shame: A grounded theory study. Dissertation, Seattle Pacific University, May 10, 2017. At: https://digitalcommons.spu.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1024&context=cpy_etd Accessed December 11, 2018.

Cochran, S. D., Drescher, J, Kismodi, E, Giami, A, Garcia-Moreno, C, Atalia, E, Marais, A, Vieira, E., & Reed, G. (2014). Proposed declassification of disease categories related to sexual orientation in the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11). *Bulletin of the World health Organization, 92,* 672-679. doi: 10.2471/BLT.14.135541

Diamond, M. (2009). 'Pornography, public acceptance and sex related crime: a review', *International Journal of Law and Psychiatry, 32,*(5), 304-314. doi: 10.1016/j.ijlp.2009.06.004

Dickenson, JA, Gleason, N, Coleman, E & Miner, H. (2018). Prevalence of distress associated with difficulty controlling sexual urges, feelings, and behaviors in the United States. *JAMA Network Open, 1 (7).* doi: 10.1001/jamanetworkopen.2018.4468

Dodes, L, & Dodes, Z. (2014). *The Sober Truth: Debunking the Bad Science Behind 12-Step Programs and the Rehab Industry*. New York: Beacon Press.

Duffy, A., Dawson, D., Moghaddam, N., & Das Nair, R. (2017). Do thinking styles play a role in whether people pathologise their pornography use? *Sexual and Relationship Therapy,* 1-22. doi: 10.1080/14681994.2017.1412417

Efrati, Y., & Gola, M. (2018) Treating compulsive sexual behavior. *Current Sexual Health Reports, 10*(2), 57-64. doi: DOI: 10.1007/s11930-018-0143-8

Elkind, A. (2010). *A rough justice: The Rise and Fall of Eliot Spitzer*. New York: Portfolio.

Fletcher, A. (2013) *Inside Rehab: The Surprising Truth about Addiction Treatment*, New York: Penguin Group.

Groneman, C. (2000) *Nymphomania: A history*. New York: Norton.

Grubbs, J. B., Perry, S. L., Wilt, J. A., & Reid, R. C. (2018). Pornography problems due to moral incongruence: An integrative model with a systematic review and meta-analysis. *Archives of Sexual Behavior*. doi:10.1007/s10508-018-1248-x

Grubbs, J. B., Exline, J. J., Pargament, K. I., Hook, J. N., & Carlisle, R. D. (2015a). Transgression as addiction: religiosity and moral disapproval as predictors of perceived

addiction to pornography. *Archives of Sexual Behavior, 44*(1), 125-136. doi: 10.1007/s10508-013-0257-z

Grubbs, J. J., Hook, J. N., Griffin, J. B. &Davis, D. (2015b). Evaluating outcome research for hypersexual behavior. *Current Addiction Reports, 2* (3), 207-213. doi:10.1007/s40429-015-0061-z

Grubbs, J. B., Stauner, N., Exline, J. J., Pargament, K .I. & Lindberg, M. (2015c). Perceived addiction to internet pornography and psychological distress: examining relationships concurrently and over time. *Psychology of Addictive Behaviors*, *29*(4), 1056-1067. doi: 10.1037/adb0000114.

Hald, G., & Malamuth, M. (2008). Self-Perceived Effects of Pornography Consumption. *Archives of Sexual Behavior, 37*(4), 614-625. DOI: 10.1007/s10508-007-9212-1

Hallberg J, Kaldo V, Arver S, Dhejne C, Öberg KG. (2017) A cognitive-behavioral therapy group intervention for hypersexual disorder: a feasibility study. *Journal of Sexual Medicine*, *14*, 950–8. doi: 10.1016/**j**.jsxm.2017.05.004

Hayes, S. C., & Strosahl, K. D., Eds. (2004). *A practical guide to acceptance and commitment therapy.* New York: Springer.

Hesse, C., & Pedersen, C. (2017). Porn Sex Versus Real Sex: How Sexually Explicit Material Shapes Our Understanding of Sexual Anatomy, Physiology, and Behaviour. *Sexuality & Culture, 21*(3), 754-775. doi: 10.1007/s12119-017-9413-2.

Klein, M. (2012). You're addicted to what? Challenging the myth of sex addiction. The Humanist.com At: https://thehumanist.com/magazine/july-august-2012/features/youre-addicted-to-what Accessed December 12, 2018.

Kleponis, P. (2010) The effects of pornography on wives and marriages. Available at: https://www.covenanteyes.com/2010/07/06/the-effects-of-pornography-on-wives-and-marriages/ Accessed December 9, 2018.

Kohut, T., Baer, J., & Watts, B. (2015). Is Pornography Really about "Making Hate to Women"? Pornography Users Hold More Gender Egalitarian Attitudes Than Nonusers in a Representative American Sample. *The Journal of Sex Research, 53*(1), 1-11. doi: 10.1080/00224499.2015.1023427

Konkola Thege, B., Woodin, E., Hodgins, D., & Williams, R. (2015). Natural course of behavioral addictions: A 5-year longitudinal study. *BMC Psychiatry, 15*(1), 4. doi: 10.1186/s12888-015-0383-3

Konkoly Thege, B., Hodgins, D.C. & Wild, T.C. (2016) Co-ocurring substance-related and behavioral addiction problems: A person-centered, lay epidemiology approach. *Journal of Behavioral Addictions, 5*(4), 614-622. doi: 10.1556/2006.5.2016.079

Kort, J. (2015). Why I am no longer a sex addiction therapist. Psychology Today Blogs. At: https://www.psychologytoday.com/us/blog/understanding-the-erotic-code/201511/why-i-am-no-longer-sex-addiction-therapist Accessed December 9, 2018.

Kraus, S. W., Krueger, R. B., Briken, P., First, M. B., Stein, D. J., Kaplan, M. S., … Reed, G. M. (2018). Compulsive sexual behaviour disorder in the ICD-11. *World Psychiatry, 17*(1), 109–110. doi:10.1002/wps.20499

Ley, D. (2012). *The myth of sex addiction*, Lanham, MD: Rowman & Littlefield.

Ley, D., Brovko, J. M. & Reid, R.C. (2015). Forensic applications of "sex addiction" in US legal proceedings. *Current Sexual Health Reports* 7(2), 108-116.

Ley, D., Prause, N. & Finn, P. (2014). The emperor has no clothes: a review of the "pornography addiction" model. *Current Sexual Health Reports, 6* (2), 94-105. Doi: 10.3138/cjhs.2017-0002

LoPresti, B.J. & McGloin, R. (2018). Pornography consumption: When we start, what we do, and why we turn off. Presentation at Society for the Scientific Study of Sexuality annual conference. Personal communication with author.

Malan, P. (2015) The naked people in your IPod. *Medium*, May 31, 2015. At: https://medium.com/@ungewissen/the-naked-people-in-your-ipod-f770a27fdb59 Accessed December 12, 2018.

McKee, A. (2007) 'The positive and negative effects of pornography as attributed by consumers', *Australian Journal of Communication*, *34*I(1), 87-104.

Nitschke, J., Mokros, A., Osterheider, M. & Marshall, W. (2012). Sexual sadism: Current diagnostic vagueness and the benefit of behavioral definitions. *International Journal of Offender Therapy and Comparative Criminology, 57*(12) 1441-1453. doi: 10.1177/0306624X12465923.

Oberg, KG, Hallberg, J, Kaldo, V, Dhejne, C & Arve, S. (2017). Hypersexual disorder according to the Hypersexual Disorder Screening Inventory in help-seeking Swedish men and women with self-identified hypersexual behavior. *Sexual Medicine, 5*(4), 229-236. doi: 10.1016/**j**.esxm.2017.08.001

Perry, S. (2018). Is the link between pornography use and relational happiness really more about masturbation? Results from two national surveys. *Journal of Sex Research*, published online January 11, 2019. Doi: 10.1080/00224499.2018.1556772

Perry, S. L., & Whitehead, A. L.. (2018). Only bad for believers? Religion, pornography use, and sexual satisfaction among American men. [Published online ahead of print January 28, 2018]. *J Sex Res*. doi:10.1080/00224499.2017.1423017.

Prause, N., Steele, V.R., Staley, C., Sabatinelli, D., & Hajcak, G. (2015). Modulation of late positive potentials by sexual images in problem users and controls inconsistent with "porn addiction". *Biological Psychology, 109*(C), 192-199. doi: 10.1016/j.biopsycho.2015.06.005

Prause, N., Steele, V.R., Staley, C. Sabatinelli, D. & Hajcak, G. (2015) Prause et al (2015) the latest falsification of addiction predictions. *Biological Psychology, 120,* 159-161. Doi: doi: 10.1016/j.biopsycho.2015.06.005

Reay, B., Attwood, N., & Gooder, C. (2015) *Sex Addiction: A critical history.* Cambridge: Polity Press.

Reed-Maldonado, A. B., & Lue, T. F. (2016) A syndrome of erectile dysfunction in young men? *Translational Andrology and Urology, 5*(2), 228–234. doi: 10.21037/tau.2016.03.02

Regnerus, M., Price, J. & Gordon, D. (2017). Masturbation and partnered sex: Substitutes or complements? *Archives of Sexual Behavior, 46*(7), 2111-2121. doi: 10.1007/s10508-017-0975-8

Reid, R. (2016). Additional challenges and issues in classifying compulsive sexual behavior as an addiction. *Addiction, 111*(12), 2111-2113. doi: 10.1111/add.13370

Reid, R. C. (2013). Guest Editorial: Personal Perspectives on Hypersexual Disorder. *Sexual Addiction & Compulsivity, 20,* 1-15. doi: 10.1080/10720162.2013.772876

Reid, R.C., & Kafka, M.P. (2014). Controversies about hypersexual disorder and the DSM-5, *Current Sexual Health Reports, 6,* 259-264. doi: 10.1007/s11930-014-0031-9

Reid, R.C., Garos, S., Carpenter, B.N. and Coleman, E. (2011) 'A surprising finding related to executive control in a patient sample of hypersexual men', *Journal of Sexual Medicine* 8: 2227-36. doi: 10.1111/j.1743-6109.2011.02314

Reid, R.C., Carpenter, B.N., Hook, J.N., Garos, S., Manning, J.C., Gilliland, R., Cooper, E.B., McKittrick, H., Davtian, M. and Fong, T. (2012) 'Report of findings in a DSM-5 field trial for hypersexual disorder', *Journal of Sexual Medicine* 9: 2868-77. doi: 10.1111/j.1743-6109.2012.02936

Rollnick, S., & Miller, W. R. (October 1995). "What is Motivational Interviewing?". *Behavioral and Cognitive Psychotherapy*, *23*, 325–334. doi: 10.1017/S135246580001643X

Schermer Sellers, S. T. (2017). *Sex, God & the conservative Church: Erasing Shame from Sexual Intimacy*. New York: Routledge

Spillius, A. (2007). Gerald Ford labelled 'sex addict' Clinton 'sick'. Telegraph. October 30, 2007. At: https://www.telegraph.co.uk/news/worldnews/1567847/Gerald-Ford-labelled-sex-addict-Clinton-sick.html Accessed December 9, 2018.

Steele, V. R., Staley, C., Fong, T., & Prause, N. (2013). Sexual desire, not hypersexuality, is related to neurophysiological responses elicited by sexual images. *Socioaffective Neuroscience & Psychology, 3*(1), 1-12. doi: 10.3402/snp.v3i0.20770

Štulhofer, A., Buško, V., & Landripet, I. (2010). Pornography, sexual socialization, and satisfaction among young men. *Archives of Sexual Behavior, 39*(1), 168-178. doi: 10.1007/s10508-008-9387-0

Štulhofer, A., Jurin, T., & Briken, P. (2015). Is high sexual desire a facet of male hypersexuality? Results from an online study. *Journal of Sex & Marital Therapy, 42*(8), 665-680. doi: 10.1080/0092623X.2015.1113585

Taylor, B., & Davis, S.M. (2007). The extended PLISSIT Model for addressing the sexual well-being of individuals with an acquired disability or chronic illness. *Sexuality and Disability, 25*(3), 135-139. doi:10.1007/s11195-007-9044-x

Watson, M. A., & Smith, Randy, D. (2012). Positive Porn: Educational, Medical, and Clinical Uses. *American Journal of Sexuality Education, 7*(2), 122-145. doi: *10.1080/15546128.2012.680861*

Wery, A., Vogelaere, K., Challet-Boujo, G., Poudat, F., Cailllon, J., Lever, D., Billieux, J. & Grall-Bronnec, M. (2016). Characteristics of self-identified sexual addicts in a behavioral addiction outpatient clinic. *Journal of Behavioral Addictions, 5* (4), 623-630. doi: 10.1556/2006.5.2016.071

Whipple, B. (2007) 'The health benefits of sexual expression', in. M Tepper and A. Fuglsang Owens (eds) *Sexual Health: Psychological Foundations (Vol 1),* Westport, CT: Praeger.

Wilt, J., Cooper, E., Grubbs, J., Exline, J., & Pargament, K. (2016). Associations of perceived addiction to internet pornography with religious/spiritual and psychological functioning. *Sexual Addiction & Compulsivity, 23* (2-3), 215-33. doi: 10.1080/10720162.2016.1140604

Winters, J. (2010). Hypersexual disorder: a more cautious approach. *Archives of Sexual Behavior*, *39,* 594-596. doi:10.1007/s10508-010-9607-2

Winters, J., Christoff, K., & Gorzalka, B. (2010). Dysregulated sexuality and high sexual desire: distinct constructs? *Archives of Sexual Behavior, 39,* (5), 1029-1043. doi: 10.1007/s10508-009-9591-6

Wright, P. (2012). A longitudinal analysis of US adults' pornography exposure, sexual socialization, selective exposure and the moderating role of unhappiness. *Journal of Media Psychology, 24,* 67-76. doi: 10.1027/1864-1105/a000063

Wordecha, M., Mateusz, W., Kowalewska, E., Skorko, M., Lapiriski, A. & Gola, M. (2018). "Pornographic binges" as a key characteristic of males seeking treatment for compulsive sexual behaviors: Qualitative and quantitative 10-week-long diary assessment. *Journal of Behavioral Addictions, 7*(2). doi; 10.1556/2006.7.2018.33

Zoellner, D. & Graham, C. (2017). Inside the sex pests' $60,000 reputation rehab featuring horse-hugging sessions, teddy bear therapy and NO tight swimming trunks which one expert brands as PR hokum. Daily Mail, November 11, 2017. At https://www.dailymail.co.uk/news/article-5073333/Inside-sex-pets-60-000-reputation-rehab-centre.html Accessed December 9, 2018.