TREATING OUT OF CONTROL SEXUAL BEHAVIOR
Douglas Braun-Harvey, LMFT, CGP, CST, is a sexual health author, trainer, and psychotherapist who bridges sexual and mental health and facilitates organizational change. In 2013, Doug Braun-Harvey cofounded The Harvey Institute, an international education, training, consulting, and supervision service for improving health care through integration of sexual health. He teaches and trains nationally and internationally, linking sexual health principles with drug and alcohol treatment, group psychotherapy, HIV prevention and treatment, and child maltreatment. Since 1993, he has been developing and implementing a sexual health-based treatment approach for men with out of control sexual behavior (OCSB). Previous publications include Sexual Health in Recovery: Professional Counselor’s Manual (2011) and Sexual Health in Drug and Alcohol Treatment: Group Facilitator’s Manual (2009). He has earned several distinctions, including the 2013 Carne’s Award from the Society for the Advancement of Sexual Health, a 2011 Sexual Intelligence Award, the 2011 President’s Award from the National Association of Lesbian and Gay Addiction Professionals, and the 2011 Society for the Scientific Study of Sexuality Western Region Public Service Award for promoting sexual health awareness and providing the intellectual framework for integrating sexology and chemical dependency. Mr. Braun-Harvey is a licensed marriage and family therapist (MFT), certified group psychotherapist (CGP), and certified sex therapist (AASECT Certified). He is on the web at www.DBHnow.com and in private practice in San Diego, California.

Michael A. Vigorito, LMFT, LCPC, CGP, is a sexual health consultant, author, and psychotherapist. As a consultant, Mr. Vigorito trains behavioral health providers to integrate sexual health into their systems of care through routine sexual health screenings, sexual risk reduction counseling, and culturally competent interventions. As a clinician, Mr. Vigorito developed, supervised, and conducted therapy in integrative behavioral health programs that worked with substance addiction, mental illness, and HIV/AIDS. In his Washington, DC, private practice, Mr. Vigorito provides individual, couple, and group psychotherapy specializing in sexual health, including out of control sexual experiences, sexual dysfunctions, sex/drug-linked behaviors, and sexual dissatisfaction. He is licensed as a marriage and family therapist (MFT), licensed clinical professional counselor, and is a certified group psychotherapist. Mr. Vigorito is also a member of the American Group Psychotherapy Association; the Society for the Scientific Study of Sexuality; and the American Association of Sex Educators, Counselors, and Therapists. More about Mr. Vigorito can be found at www.iCounselingServices.com.
TREATING OUT OF CONTROL SEXUAL BEHAVIOR

RETHINKING SEX ADDICTION

Douglas Braun-Harvey, LMFT, CGP, CST
Michael A. Vigorito, LMFT, LCPC, CGP
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FOREWORD

Over 100 years ago, Freud discussed his theories about sexuality, describing how repression and the cultural mores of Victorian society, as well as the unchained instinctual search for pleasure, significantly disrupted child development and the behaviors of adults. He would be totally amazed and confused by the lack of repression and the flaunting of sexuality in every aspect of modern Western life. He might assume that the release of repression and the advances in our understanding of sexuality would bring enlightenment, intelligent and open conversations about sexuality, and a clear perspective on the role of healthy sexuality in human development and behavior. Unfortunately, such is not the case. Sexual assault, rape, pedophilia and other nonconsensual sexual behaviors, as well as a host of other consensual or solitary sexual activities and sexual risk-taking behaviors abound in our society. Freedom often becomes license. Sexual behaviors, which are inherently reinforced and evolutionarily important, spiral out of control for individuals, for our institutions—like college campuses and the military—and for our society as a whole.

Human sexuality is an integral part of being human and the foundation of intimate relationships and a healthy society. It is not a necessary evil or something that should be shrouded in secrecy and shame. Pathologizing, stigmatizing, labeling, and criminalizing deviations from what are considered “acceptable” sexual behavior have not helped individuals and, more important, societal leaders and healers to understand sexual health or to adequately address sexual behaviors that feel out of control. As with all appetitive human behaviors, the goal is to manage and self-regulate so that the behavior is in the zone of what I call “self-regulated behaviors” that are under self-control and are upregulated or downregulated as needed based on internal and external feedback about the behavior. However, all appetitive behaviors can spiral out of control—seeking satisfaction without responsibility, engaging in repetitive patterns that are harmful—bringing serious consequences and becoming less and
less pleasurable as they become more and more automatic and excessive. Such are the out of control sexual behaviors described in this book.

However, the focus should not be solely on loss of control or problematic sexual behaviors. As described in the World Health Organization’s (WHO; 2006, p. 6) definition of sexual health, the focus should be on “physical, emotional, mental and social well-being in relation to sexuality.” Yet, sexual health involves an even larger conversation, and should be focused on “pleasurable and safe sexual experiences, free of coercion, discrimination and violence” (WHO, 2006, p. 6).

Doug Braun-Harvey and Michael Vigorito have entered the field of human sexual behavior with a clear perspective on the discipline’s extensive history of confusing and conflicting conversations and research about excessive and harmful sexual behaviors. Their focus on out of control sexual behaviors and the deeply humanistic and respectful manner in which they address these behaviors is not only refreshing but offers all providers an exciting new view and innovative way of addressing these behaviors in an effective, compassionate, and client-centered manner. In this volume, they help providers to begin to confront the often hidden prejudices and superficial knowledge about sexuality that they bring to conversations with clients. Offhand remarks, embarrassed silence, stigmatizing comments, or complete uncritical acceptance are not the foundation for the types of conversations that individuals engaging in out of control sexual behaviors need. The process of change must begin with an understanding, open, caring, and collaborative conversation with any client considering whether, how, and what to change.

Although focused on out of control sexual behavior (OCSB), this volume offers a wealth of information about sexual health and how conversations about sex must move beyond sexually transmitted disease and pathology. We must shift the focus from “using condoms and protecting against pregnancy” to how to appreciate and understand our bodies and engage in behaviors that enable us to be physically, mentally, and sexually healthy and happy. Sex in the shadows, survivor sex, shame and stigma, as well as adverse early sexual experiences and poor education lead to the silence and secrecy that undermine sexual health. The wealth of information and the assessment and intervention strategies highlighted in this book can enable therapists and providers of all types to effectively bring the sensitive topic of sex into the daylight and open air of constructive conversations. Braun-Harvey and Vigorito offer a comprehensive and clear discussion and framework for addressing sexual health and out of control sexual behaviors in a collaborative and motivationally enhancing manner.
The process of change is a journey, and clients need empathy, support, accurate information, feedback, guidance, and the skills to make the change. These are needed so clients can successfully negotiate the multiple tasks of the journey to successful and sustained change. This book offers the authors’ wisdom, accumulated through many years of experience helping people change, both in individual counseling and in groups focused on sexual health. Their experience makes the case vignettes and the many interactions highlighted in the text real and relevant. The principles and practices outlined here are very well described and come alive with the many and varied vignettes describing interactions between clients and counselor. Even more interesting, they describe some conversations between Doug and Michael as they colead groups and do not always agree on the best way to ask a question or make an intervention. This dialogue offers a way for the reader to explore different approaches and to understand that approaches to intervening with a client on any specific topic involving a choice should reflect thoughtful and sensitive listening to the client; empathy; and sound, critical self-assessment.

I am currently completing a collaborative project funded by the Substance Abuse and Mental Health Services Administration, titled “No Wrong Door,” that is attempting to ensure that individuals entering primary care, mental health, and substance abuse portals seeking treatment will be assessed and offered treatment for all their concerns. More important, when needed, these individuals will be offered counseling not only for sexual risk reduction but also for sexual health. As we attempt to undertake this challenge, we need well-trained counselors who are able to address the sexual health needs of clients. One hopes this volume will empower generations of counselors to be more proactive and effective in meeting the needs of individuals with “out of control sexual behaviors” that often lead to significant interpersonal, social, and personal consequences, with the goal of helping them to achieve and maintain sexual health.

CARLO C. DICLEMENTE, PhD, ABPP

REFERENCE

INTRODUCTION

Compulsive sexual behavior and sexual addiction treatment models were introduced over 30 years ago and sparked a debate that has yet to be resolved. Is sexual behavior dysregulation a disease rooted in a process addiction or a disorder stemming from a psychosexual pathology? With hundreds of sexuality, addiction, neuroscience, and psychological studies and thousands of psychotherapists providing specialized clinical interventions, there is still no consensus regarding etiological or best treatment practices for out of control sexual behavior (OCSB). However, the lack of scientific and clinical consensus has not discouraged men and women from seeking help for what they experience as sexual dysregulation. During these same three decades, the World Health Organization, the U.S. surgeon general, and other distinguished bodies began defining the concept of sexual health. Since the mid-1970s, notions of sexual health moved beyond the absence of sexually transmitted diseases and unintended pregnancies to encompass issues of human rights, consent, nonexploitation, pleasure, and access to sexuality education. Just as definitions of sexual health moved beyond the focus of disease prevention and treatment, could current discourse benefit from shifting the focus toward a sexual health approach for understanding and treating sexual behavioral problems?

Treating Out of Control Sexual Behavior: Rethinking Sex Addiction is our sexual health approach for the assessment and treatment of cisgender men motivated to change consensual sexual behavior that feels out of their control. In the following chapters, we introduce our conceptualization of OCSB and our assessment and treatment pathway, which grew from many years of providing individual and group psychotherapy to men of all sexual orientations motivated to improve their sexual health.

We began this project by delving into the literature on sex addiction, impulsive/compulsive sexual behavior, and hypersexual behavior. We were dispirited by the emphasis to establish and defend a singular
pathological pathway or clinical disorder that did not reflect the symptom complexity found among our clients. It was common to read studies that merged consensual and nonconsensual sexual behaviors in their population samples or clinical approaches. Further, emerging substance addiction neuroimaging research was often overgeneralized and too eagerly cited as support for sexual addiction etiology. This resulted in sociocultural sex negativity being camouflaged within medical or mental health language while premature conclusions advanced diagnostic labels despite the lack of randomized clinical trials, evidence-based practices, or scientific consensus. Diagnostic labels were proposed as psychiatric disorders only to be rejected for lack of scientific agreement.

Absent a theoretical and clinical consensus among mental health professionals, our research expanded to human behavior and wellness literature. This led to articles and models that shed light on problems of decision making, self-regulation, and behavior. We studied positive psychology, sexology, attachment theory, mindfulness, and behavioral economics. We became increasingly interested in resolving men’s sexual behavior problems by moving them toward sexual health rather than limiting treatment to what seemed an increasingly moribund goal of diagnosis and amelioration of a contentiously debated pathological state.

Our primary task was to synthesize and apply this diverse literature to OCSB treatment. It was not until we read the work of integrative psychotherapists that we fully appreciated what we had undertaken. Integrative psychotherapy explains human behavior by integrating physiological, affective, cognitive, behavioral, and systemic approaches understood within stages of human development and the wide range of human functioning (Erskine & Moursund, 2011). Integrative psychotherapy principles construct frameworks for understanding the multivariate factors that contribute to complex behavioral problems. The integrative psychotherapy mission, to join components of effective therapy that cut across theoretical approaches and client populations, affirms our investment in psychotherapy best practices as a foundation for OCSB assessment and treatment.

Our purpose for writing *Treating Out of Control Sexual Behavior: Rethinking Sex Addiction* is to provide clinicians a resource for establishing an individual and/or group psychotherapy relationship with men wanting to change and to improve their sexual health. Numerous books have been written that prescribe generalized counseling techniques for anyone in sexual addiction treatment. Absent from much of the materials was how to be a sexual addiction therapist in relationship with clients.
In his recent article, “What Should We Expect From Psychotherapy?” Stony Brook University psychologist Marvin Goldfried (2013) summarized five common change principles in effective psychotherapy:

1. Fostering the expectation that therapy can help
2. Forming an optimal therapeutic alliance
3. Raising client awareness about the factors contributing to their problems (in themselves, others, and their environment)
4. Facilitating corrective experiences
5. Ongoing reality testing

He additionally cites client motivation to change (Prochaska & DiClemente, 2005) along with interventions that enhance motivation (Miller & Rollnick, 2013) as significant components for effective therapy. The therapeutic alliance, however, is viewed as “most essential to the change process,” which includes the therapeutic bond and the agreement on goals and methods by client and therapist (Goldfried, 2013, p. 867).

Our emphasis on the collaborative therapeutic relationship and creating a unique vision of each man’s sexual health vision distinguishes OCSB treatment from most current addiction and psychosexual disorder models. Rather than proscribe a series of tasks for the client to complete under the direction of a trained certified therapist, this book guides clinicians on how to be a therapist in relationship with men seeking to build and define a personal vision of sexual health.

We were inspired by Goldried’s “change principles” when structuring the three sections of Treating Out of Control Sexual Behavior: Rethinking Sex Addiction. Section 1 establishes the foundation for a sexual health approach to addressing out of control sexual behavior. In it, we review how our sexual health framework supports essential relationship skills to prepare client and therapist to enjoin in a collaborative process of change. Further, we introduce a dual-process model of human behavior to contextualize the internal and external factors that contribute to a client’s out of control sexual behavior. Section 2 outlines the OCSB screening procedure and assessment plan. We describe the dual purpose of identifying vulnerability factors and competing motivations that contribute to a client’s out of control sexual behavior and the psychotherapy techniques research suggests enhance client motivation for behavior change. Section 3 builds on the previous two sections by discussing combined individual and group therapy principles and practices designed to facilitate corrective emotional experiences and support men moving toward their personal vision of sexual health.
We begin the book by introducing you to composite client stories compiled from over 250 men treated since 1993. The book ends with treatment highlights from four of these cases. Sprinkled throughout the book are sample client dialogues that provide examples of individual and group psychotherapy to illustrate a particular aspect of the OCSB Model.

**PROTOCOL DESIGN METHODS**

We also want to be transparent about our motivations for applying the research and literature presented in the book. Evidence-based practices guided the development of our OCSB treatment model. However, the OCSB Clinical Pathway is also an outgrowth of integrating these studies with actual client symptoms and narratives. As so many clinicians know, the realities of practice require consistent decision making, flexibility, and reevaluation that are not always mirrored in social science experiments. Each OCSB protocol component balances the scientific literature with our clinical experience.

We first presented the early musings for our model at the 2008 Society for the Scientific Study of Sexuality, Western Region (SSSSWR) conference. In the ensuing 7 years, we have presented adaptations and refinements of what is now this book. We want to thank SSSSWR as well as the American Association of Sex Educators, Counselors and Therapists (AASECT), Society for the Advancement of Sexual Health (SASH), American Group Psychotherapy Association (AGPA), California Association of Marriage & Family Therapists (CAMFT), and the national meeting for the Society for the Scientific Study of Sexuality (SSSS) for providing opportunities for much needed dialogue and critical thinking in the development of our treatment method. In 2012, we conducted several external review sessions in San Diego to ascertain feedback from invited therapists, researchers, addiction treatment professionals, and sexologists. We are immensely grateful for the many esteemed colleagues from psychotherapy, sex research, sex therapy, and forensic psychology who agreed to preview and critique early chapter drafts.

**PROTOCOL DESIGN INFLUENCES**

Vetting the OCSB protocol did not remove our personal values from the protocol design. We began to see the influence of our personal experiences when we were formulating ethical principles for OCSB treatment.
Our emphasis on establishing an ethical foundation could not be separated from living as gay men in the 35-year shadow of the AIDS pandemic. A seminal historical narrative for us was remembering when providers were caught up in the sexual panic of the early stages of the AIDS crisis before the countervailing forces of public health research and patient-rights advocacy reshaped health care delivery. As a consequence of this legacy, we were skeptical of psychotherapeutic techniques designed to treat clients with sexual behaviors considered socially unacceptable and treated in the absence of rigorous scientific research. As a result, we grounded the OCSB Model in ethical standards of care to promote a psychotherapy space free of the similar sexual stigma that often contaminated the relationships between patient and provider during the AIDS crisis.

We regard the therapeutic alliance as the highest priority when conducting OCSB treatment. To best establish this relationship, it is incumbent upon providers to conduct a thorough self-evaluation to address any personal discomfort with sexual diversity that may interfere with their ability to empathize and join with their clients whose sexual behaviors are often deemed disgusting, perverted, dangerous, excessive, sinful, and unhealthy by mainstream society. We suggest you read this book with both your professional mind as well as a personal process for self-reflection. How do your life experience and sexual values influence your work? How do you resolve personal and professional discomfort with detailed sexual health conversations? What checks and balances do you use to suspend your judgments that, left unchecked, will inevitably disrupt the therapeutic alliance?

A SEXUAL HEALTH ALTERNATIVE

Without existing scientific or psychiatric consensus to establish a sexual regulation disorder, we built our model on the assumption that OCSB is a behavioral problem. We are open to a sexual disorder that differentiates a subgroup of consensual out of control sexual behaviors, but only after compelling evidence delineates a specific sexual pathology from a scientific process free of sexual judgments and cultural disapproval. We define OCSB as a sexual problem of consensual sexual urges, thoughts, or behaviors that feel out of control for the individual. We contextualize OCSB within a theory of human behavior on which clinicians organize the client’s sexual health problems within principles of sexual health and focus change in the direction of each man’s personal sexual health goals. We assess vulnerability factors and competing motivations that research
suggests contribute to negative and dysregulated sexual experiences. The assessment process produces a Unique Clinical Picture to guide OCSB treatment. The combined individual and group treatment interventions are designed to address each man’s vulnerability factors and competing motivations that impede his ability to achieve his vision of sexual health. The OCSB Clinical Pathway outlines a sequence for screening, assessment, and treatment of out of control sexual behavior.

We do not propose an essential method that “should” be universally applied by treatment professionals to treat OCSB. We offer a protocol for a sexual health dialogue in which clients define and realize their personal vision of sexual health. Sexual health conversations remain a rare and privileged exchange and are essential for treating OCSB. Ultimately, our hope is that by sharing our thoughts with you, the reader, we provide a clinical pathway to integrate within your current clinical practices, help foster curiosity with your clients, and expand your clinical approach in treating problematic and out of control sexual behavior in whatever professional context you work.

**REFERENCES**


SECTION ONE

A Sexual Health Foundation
CHAPTER ONE

THE STATE OF THE FIELD

DAVID

It was my sixth appointment with Veronique and Jay. Married 8 years, they were in couple therapy for communication problems and overall relationship dissatisfaction. Sitting on the far side of the waiting room with her arms folded, Veronique stared straight ahead. Jay, with his head buried into his hands, was unaware that I entered the room. “David’s here,” Veronique said curtly as she stood up and walked past me to my office. Jay slowly followed.

I was barely in my chair before Veronique looked at me and asked, “Are you ready to hear a new one?” Her eyes were tearing. “I found it all” she said, louder and angrier. “He’s been lying the whole time. I looked at his e-mail and found a secret account he’s been hiding from me. Apparently he goes online and looks at porn and talks to women. He has files of pictures. It made me sick!”

Jay looked at me and said, “I got rid of it all, I don’t want to do this anymore.”

Veronique barely let him finish before yelling, “I can’t believe a word you say! You’ll say anything right now!” Jay looked at me silently.

CHARMAINE

As part of my graduate school internship, I co-led a weekly adult outpatient drug and alcohol treatment group with my supervisor. Susan was a highly respected and experienced certified drug and alcohol counselor. Each year, Susan welcomed a new intern to train with her as a coleader in
her treatment groups. In the 3 months that I had been working with Susan, the group’s membership increased from five men and women to nine. Around this time, one night’s group began with Hector saying he had something to talk about. He was hesitant, choosing his words carefully.

Hector said, “I know we hardly ever discuss this, but I need to be honest about something that happened this week. I went to a clinic, an STD [sexually transmitted disease] clinic, because I was worried I might have something. Well, it turns out I did. I tested positive for gonorrhea. They gave me some meds and everything will clear up soon. But, I had to tell Phil, my partner. He was so mad. He said that he was done. That he was tired of my lying and drinking. I have been staying at my sponsor’s house. I haven’t used, but I am afraid and don’t know what to do next.”

I sat very still, staring at Susan for guidance.

**BETH**

As a psychiatrist in an outpatient medical group, I provide mostly diagnostic assessments and medication. My first appointment this afternoon was with Frank. I have been treating Frank’s generalized anxiety disorder since it was first diagnosed 5 months ago. Frank has reported steady symptom reduction, so I anticipated an uneventful appointment. I noticed Frank’s poor eye contact when he entered my office. He seemed distressed. After we were seated, I asked, “How are you?”

“I’m doing OK, except … I have something I have to talk about,” he replied.

Frank paused, his body motionless.

“You seem nervous about something,” I said.

After several deep sighs, he murmured, “I need to talk about what happened at work. My boss called me into his office last week. They found out that I was downloading porn at my desk. I’d been doing this for years. My boss told me it had to stop or I’ll be fired … I can’t lose my job! I couldn’t believe I got caught. I’m so stupid!”

**LYNN**

When I scheduled my first appointment with Peter, he mentioned that he was married with three children and was troubled about something that was affecting his relationship. Within the first minutes of this session, he recounted a recent conversation with his minister.
“I talked with him about what I’ve been doing and he suggested that I see someone. You were the closest therapist who took my insurance, so I’m hoping you can help me. Raising three kids, I don’t have much time or money to spend on therapy. But this is important.”

“I’m glad you were able to make it in,” I said. “You mentioned that your minister recommended therapy. What was the reason for the suggestion?”

“I’ve been cheating on my wife since we’ve been married. Every couple of weeks I watch porn on the computer. I know I shouldn’t. I should only feel that way toward my wife, but sometimes I can’t help it. When I told that to my minister, he said that I might be addicted to porn and that if I wanted to honor the vows of my marriage, I needed to stop. Is that something you can help me with? To only have sex with my wife?”

DANNY

Will tested HIV positive a couple of weeks ago. I usually see clients who have been living with HIV for several years, but, working as a psychologist at an HIV mental health clinic, newly diagnosed clients are occasionally scheduled. When he came in for his first appointment, he was outwardly upset.

“I have no one to blame but myself,” Will exclaimed. “I’ve been out long enough to know better. But, I was careless. And the person who gave me my results drove that point home. The lady said I was a sex addict and should get treatment”

“What do you mean?” I asked.

“On her form, she needed to know how many sex partners I had over the past year. … I’m not completely sure, so I said 10 guys, but it’s probably more like 20. I didn’t think 10 was that many compared to some of my friends, but she suggested that I try to reduce the amount of partners I have. Then, as if to confirm my carelessness, she tells me I’m positive and to get help for my sex addiction.”

AMY

As a hospital social worker, I’m frequently asked to intervene when patients exhibit behavioral problems on the unit. Last month, I was working with Anthony, a single, 29-year-old man recovering from injuries related to a car accident. He was a sweet man who was handling his
misfortune well. At least, that was my initial impression until I heard from one of the nurses that she walked in on him masturbating. That is not terribly uncommon, but it was the second time it happened with this patient and I overheard a nurse refer to him as a pervert. So, I thought I should check in to get a better understanding of what was happening.

At first, he denied that he was masturbating, which was curious, because that was not the issue. I was attempting to tell him how to masturbate appropriately, such as in the adjoining bathroom. But, the more defensive he became, the more suspicious I became. And then I realized—my assumption that he was accidentally discovered was incorrect.

“The nurse mentioned that there’s been a couple incidents where they’ve walked in on you …” I began.

Interrupting, Anthony said, “Look, I’m sorry. I didn’t mean to upset anyone. I feel really bad. But, honestly, I’m not sure why I did it. I promise that I won’t do it again.”

**MOMENT OF DISCLOSURE**

David was faced with an intensely emotional moment involving a sexual dispute between intimate partners. Charmaine, like so many newly trained professionals, withdrew when presented with a detailed sexual disclosure and looked to her coleader/supervisor for guidance. Beth and Lynn were presented with clients in distress about their solo sexual behaviors, Danny’s client was dealing with the consequences of his multiple-partnered sex, and Amy was faced with managing a sexual boundary violation.

Consider your response to these scenarios. What did you notice about yourself? How did you imagine yourself feeling? How would you have responded? Although these vignettes contain brief interactions, they are glimpses into clinical moments during which sociocultural conflicts about sexual dysregulation live and breathe among clinicians. Your reactions to these case examples (or response to real-life client sexual disclosures) provide insights into how the past 30 years of theoretical debate over sexual behavior problems have influenced your work. Despite the many tensions that currently exist in sociocultural, sexological, and psychological debates surrounding sexual behavior problems, therapists are still expected to assess and intervene when presented with these clinical situations. Like members in a quarreling family, our actions and reactions are affected by the tensions of the greater systems in which we reside.

We begin this book with clinical situations inspired by either Doug or Michael’s clients or professional case consultations. More information
about the clients Jay, Hector, Frank, Peter, Will, and Anthony unfold throughout the book. We follow these clients from the moment of disclosure to treatment completion as we introduce the assessment and treatment components of a process we call the Out of Control Sexual Behavior (OCSB) Clinical Pathway. Before delving into the OCSB treatment protocol or discussing clinical applications for problematic or OCSB, we focus on the therapist providing the service.

THERAPIST PREPARATION

Research suggests that the therapeutic alliance is essential for effective psychotherapy (Goldfried, 2013). The relationship between clinician and patient is more closely correlated with positive outcomes and is more often correlated with effective treatment than is the therapist’s theoretical approach or matching of his or her clinical theory with a specific client population. The importance of this therapist and client partnership requires the interpersonal relationship to mature within each clinical relationship and sustain over the course of psychotherapy. Miller and Rollnick’s third edition of Motivational Interviewing (2013) elevates the importance of the relational process by identifying it as the “spirit of Motivational Interviewing” (MI; p. 14), without which MI might be misconstrued as a set of tricks to influence clients to do what the therapist wants a client to do. To prepare for the complexities of facilitating sexual health conversations, we place a similar emphasis on the relationship components Miller and Rollnick identify as comprising the spirit of motivational interviewing: partnership, evocation, acceptance, and compassion.

Throughout this book, you will notice the prominence we place on client motivation for change. Central to OCSB treatment is a process for therapists to use to raise client awareness regarding their sexual behaviors with the goal of uncovering and evoking each man’s motivation for change. Client motivation shapes OCSB clinical questions and the direction for OCSB treatment. The substance of therapist OCSB interventions stem from what the client wants to achieve for his sexual health rather than the sexual-disorder symptoms he should overcome or what the therapist thinks is sexually appropriate. OCSB treatment is ultimately a process for men to better understand the motivations behind their sexual behaviors and use this wisdom to improve their sexual health. The therapist and client relationship collaborate to clarify and maintain each client’s personal vision of sexual health. In concordance with Miller and Rollick’s (2013) strength-based approach to change, we designed our treatment protocol
to optimize therapist and client curiosity about the client’s behavior. It is this curious stance that provides a process for men to understand their OCSB as an attempt to fulfill honorable needs with problematic solutions.

The aspects of acceptance Miller and Rollick (2013) highlight stem from the work of Carl Rogers (1980): accurate empathy, absolute worth, autonomy, support, and affirmation. The concept of acceptance has particular significance in the treatment of sexual behavior problems because the various actions presented in treatment are often socially inappropriate, harmful to themselves and others, or criminal. People who engage in high-frequency sex, commit acts of infidelity, or become infected with sexually transmitted infections (STI) are often portrayed in the media as immoral, promiscuous, and unsympathetic. People with sexual problems or unconventional sexual interests are often deemed unworthy or undeserving of empathy. An acceptance stance is less likely among clinicians lacking adequate sexual health conversation skills and who implicitly or explicitly react disapprovingly to their clients’ sexual behaviors. Unexamined personal sexual values and attitudes hinder therapist efforts to earnestly maintain an actively curious interest in the internal worlds of their clients. Consider whether the psychiatrist Beth would be able to remain empathetic with Frank after he disclosed his history of watching sex videos if she strongly believes porn exploits women. Or Charmaine, who during group therapy has a passing thought that Hector invited these consequences on himself. Or whether Amy felt repulsed by Anthony exposing his erect penis to the nursing staff. Prizing “the inherent worth and potential” (Miller & Rollnick, 2013, p. 17) of clients regardless of the sexual acts they have committed is a radical notion that is not fully realized in general psychotherapy training and practice.

The promotion of another’s sexual health also depends on the therapist providing compassionate care. “Who is entitled to compassion?” is a common struggle that occurs when sexual problems arise in relationships. A client may arrive at the office as the “identified patient” because he did not honor his commitment with his romantic partner. Clients may assume that the therapist will withhold empathy for their situation until they have corrected the problematic sexual behavior. It is important for therapists to be prepared for this client assumption and avoid preconditions for forming the therapy relationship. This can be seen in men attending OCSB sessions as a condition of remaining married. In this circumstance, therapy risks becoming primarily a vehicle for the injured spouse’s need for healing and security. Therapists will need to quickly differentiate the newly forming therapeutic relationship from the injured spouse’s perceptions that compassionate therapy is an endorsement of client’s exploitative and dishonest sexual behavior. OCSB treatment
prioritizes establishing a therapy relationship conducive to the process of change, even when the client or his significant other might not believe he deserves it.

A variety of factors impede the therapist’s attempts to establish an optimal relationship and apply the spirit of MI when sexual behavior problems are the presenting problem. We emphasize therapist preparation for conducting OCSB assessment and treatment because it is vital for therapists to stay attuned and connected when sexuality is the topic of psychotherapy. Two areas of preparation we highlight are therapist’s knowledge and comfort with facilitating sexual health conversations.

**Therapist Knowledge**

The U.S. health care system has shown a lack of integration of sexual health knowledge. There is an even deeper void when men and women in this country present with sexual behavior problems. As surprising as this may sound, the vast majority of medical and mental health providers in the United States are under-trained, and personally uncomfortable with talking about sex. Sexologist Peggy Kleinplatz links health care training and confidence deficit with a general reluctance among health care professionals to initiate sexual health conversation with their patients (Kleinplatz, 2012). Although basic coursework in human sexuality is required at some institutions that offer training in these professions, a sexual health domain is rarely integrated into physician, nursing, psychology, social work, marriage and family therapy, addiction counseling or professional counselor curriculums, or postgraduate training (Maurice, 1999). In graduate and postgraduate training, most mental health professionals only learn introductory knowledge about sexual disorders. But, training that covers the enormous diversity of child, adolescent, and adult sexuality (Kleinplatz, 2012), and how to facilitate effective, person-centered sexual health conversations is limited. A recent forum to address gaps in medical school sexuality education found “little instruction on sexual health in medical schools and little consensus around the type of material medical students should learn. To address and manage sexual health issues, medical students need improved education and training” (Coleman et al., 2013, p. 924).

Postgraduate training for mental health professionals interested in treating sexual behavior problems is also limited. For example, sexual addiction certificate training programs lack a curriculum to develop therapist sexual health knowledge or sex therapy skills. The International Institute for Trauma and Addiction Professionals (IITAP), a limited
liability company (LLC) that trains mental health professionals in sexual addiction treatment, has a well-defined process for sex addiction (SA) treatment certification (certified sex addiction therapist or CSAT), but requires no advanced training in human sexuality or sexual health. There is no comparable organization that provides a certification process for impulsive–compulsive sexual behavior (ICSB) or hypersexual disorder (HD) treatment. Some workbooks on sexual compulsivity, sexual addiction, and cybersex integrate sexual health concepts (Edwards, 2011; Edwards, Delmonico, & Griffin, 2011). However, these books are patient resources and do not address specific sexual health training or skills for professionals, nor do they advise their readers to evaluate their therapist’s level of postgraduate sexual health and sex therapy education (e.g., Carnes, 2010; P. Hall, 2013; Magness, 2013).

The American Association of Sexuality Educators, Counselors and Therapists (AASECT) offers a process to become a certified sex therapist (CST). The AASECT certification process emphasizes treating sexual disorders and dysfunction. This focus reflects the origins of sex therapy to improve the psychological treatment of sexual functioning and satisfaction (Giugliano, 2004). Because OCSB is currently not recognized as a disorder or dysfunction, the AASECT certification process implicitly disregards OCSB education and skill development as an expected core treatment skill among CSTs. Unfortunately, a clinician may obtain a sex therapy certification without any education or supervised clinical experience in treating OCSB.

We believe medical and mental health sexuality education deficits leave providers, certified or otherwise, unprepared for the complexities of sexual health conversations and OCSB treatment. As a result, providers too often rely on limited sexological or sexual health knowledge. These knowledge gaps can inhibit clinical inquiry about client’s sexuality (Harris & Hays, 2008), undermine treatment planning for sexual behavior problems, and contribute to therapist discomfort with sexual health conversations.

**Therapist Comfort**

Harris and Hays’s (2008) survey of marriage and family therapists found a correlation between therapist discomfort with sexual topics and their unwillingness to initiate sexuality-focused interventions. Therapist knowledge, in and of itself, was insufficient for the survey respondents to reliably initiate or feel comfortable with clinical discussions about sex. Instead, the more discomfort the therapist felt about discussing sexual topics, the more therapists avoided initiating sexual conversations with their clients. An avoidant therapist risks not seeing the biases and treatment
responses that deter the client from continuing to discuss sex. Therefore, we first address common emotional entanglements of avoidant therapists that contribute to their inability to address client sexual behavior problems before we turn our attention to our OCSB conceptualization and treatment protocol.

When therapists avoid sexual health conversations, it replicates the client’s similar avoidance of uncomfortable affect states. There are not many topics in life that can generate discomfort like sex. What prevents sexual openness in the therapists will hinder them from initiating or addressing sexual health matters in session (Schnarch, 1991). Many health care professionals find themselves unprepared to manage their emotional activation in tandem with the clients’ sexual presenting problem. The therapist’s emotional activation may override his or her capacity for critical thinking and adversely influence his or her clinical responses with clients. The source of therapist activation could be anything. It may relate to personal discomfort about the details of his or her sexual behaviors or turn-ons. Therapists may have a historical or recent sexual violation that still hurts. They may be in the midst of resolving an intense regret over a recent sexual choice in their own lives. Without self-reflection regarding sexual discomfort, even the most experienced psychotherapists will lose their well-honed confidence and clinical acumen when a client reveals a sexual behavior problem.

Therapist defenses look different for each therapist. One way to understand therapist defenses in response to a client’s talking about sex is to group them as an under response or an active, but judgmental response. V. W. Hilton (1997) observed that the most common failure of therapists is to avoid sexual issues altogether. These are the underresponders. This pattern was observed in Harris and Hays’s (2008) research, which found a correlation between therapist anxiety regarding sexuality-related topics and low frequency of therapist initiation of sexual-related conversations with their clients. All too often, therapists rely on the client to initiate a discussion regarding an aspect of their sexual behavior that is dissatisfying. In this scenario, the therapist’s avoidant defenses collude with client’s avoidant defenses. General questions about client’s satisfaction with his or her sexual behavior, function, and pleasure, as well as a discussion of sexual problems or sexual health are absent from treatment. A therapist’s avoidance of sexual topics creates unnecessary burden and disincentive for clients who feel uncomfortable talking about sex to initiate a sexual health conversation. Faced with their therapist’s avoidant defenses, clients might observe nonverbal facial cues, changes in therapist rate of speech, or interventions that steer the discussion away from sexual health. Clients may choose short-term relief from their own
discomfort and follow the therapist’s lead to a less anxiety-provoking topic. Clients are left with the choice to either tolerate the negative consequences associated with their sexual problems or push through their discomfort with talking about sex to address their sexual problem. It is a high price to pay for access to sexual health care.

Clients who link a specific negative consequence with their sexual behavior will often initiate talking about their sexual behavior with their existing therapist or find a therapist to help them with their sexual concerns. If therapists are not ready to facilitate an open discussion about a client’s emerging self-discrepancy with his or her sexual behavior, they may simply move the focus toward a psychotherapy model, notion, or concept in which the therapist feels comfortable and professionally literate. For example, on hearing Hector disclose his gonorrhea infection and his relationship crisis, Charmaine and Susan might have moved the group discussion to the relapse risk linked with Hector’s emotions resulting from this severe relationship crisis. They might quickly affirm Hector’s clear determination to stay sober. They might even suggest he look into going to a 12-step program for sexual addiction. All of these responses could be motivated by one or both of the group therapists’ anxiety and discomfort with discussing the specific sexual behavior details that resulted in Hector contracting an STI.

The active but judgmental therapist defense contributes to values-laden clinical interventions that negatively influence treatment. When therapists lack a sexological knowledge base acquired through medically accurate and scientifically informed sexuality education, they unfortunately rely on their personal experience, values, and attitudes to clinically respond to their client’s sexual concerns. For example, Ford and Hendrick (2003) found therapists with a conservative sexological worldview tended to view their clients with multiple sexual encounters as having more pathology than the monogamous clients, who reflected their own values and sexual ethics. Hertlein (2004) studied psychotherapist conceptualizations of Internet infidelity. The therapists in this study attributed a significantly higher degree of SA to male clients and considered their female clients who viewed online pornography as atypical. Interestingly, men’s online sexual activity was not considered unusual by the therapists in this study when the men engaged in the same frequency or kind of online sexual behavior as their female clients. This is consistent with the findings of Seem and Johnson (1998), who studied therapist responses to client gender-atypical behavior. In this study, therapists were more likely to respond negatively toward clients who did not act in a gender-stereotypical manner than toward their clients who acted in a manner consistent with expected gender norms. In addition, Hertlein
(2004) found correlations between therapists labeling client online sexual behavior as a sexual addiction and the therapist’s level of religiosity. The clinicians who self-identified as more religious among the study participants were more likely to rate married clients’ online viewing of sexually explicit material or Internet sex-chatting as a serious problem or as a sexual addiction.

These studies suggest a troubling circumstance in psychotherapy that arises when a therapist’s lack of knowledge, discomfort with talking about sex, and lack of preparation for sexual health conversation aligns with a client’s defenses against talking about his sexual activities and behavior. Perhaps assigning a sexual addiction or compulsive sexual behavior label unwittingly allows both client and therapist to each avoid uncomfortable emotions when talking about the intricate details of sex. Could it be that many psychotherapists and their clients prematurely move toward diagnosing sexual behavior as an addiction or compulsion to defensively avoid the painstaking intricacies of assessing each man’s specific circumstances? This encourages clients to quickly experience the relief felt when accepting a therapist’s diagnostic label as a support to their motivation to “get on” with treatment and to prevent whatever dire consequence is at hand (e.g., ending their marriage, job, or child custody). When therapists avoid uncomfortable sexual topics or fill their knowledge gaps with sociocultural judgments, they sacrifice developing an informed clinical picture.

We hope the screening, assessment, and treatment protocol described here helps therapists remain grounded in person-centered principles of psychotherapy by offering a map to facilitate a sexual health conversation with clients concerned about problematic sexual behaviors and OCSB. This book can also be part of a preparatory step toward increasing your sexual knowledge and comfort to facilitate client sexual health conversations. But, as we just discussed, knowledge alone is not enough to safely and effectively conduct sexual health conversation. It is imperative that therapists develop an ongoing self-awareness process to identify and resolve their discomfort and knowledge gaps when talking about sex.

A BRIEF HISTORY OF THE DEBATE

We move from the internal focus of therapist comfort and ability to talk about sex to a review of the various external factors that influence a psychotherapist assessment and treatment for OCSB. We review our perspectives of how the sociopolitical history surrounding diagnosis and
treatment for sexual behavior problems led us to a sexual health model for OCSB. We also highlight sexual science research that informs the debate among various models for sexual behavior problems. We believe it is important to understand both the science and the cultural influences that intersect and contribute to the current controversy surrounding basic ideas and clinical approaches for OCSB treatment. Some readers may be very familiar with the historical markers that inform the existing circumstances. For others, our review of the competing models of sexual behavior dysregulation may be an important historical context to better understand our motivation and intent for proposing a sexual health approach to OCSB treatment.

**Sexual Behavior Clinical Disorders**

Simon Andre Tissot’s *Treatise on the Diseases Produced by Onanism* (1832) has had an enormous influence on European and American medicine. Prior to germ theory, body fluids were a significant focus of medical theory and treatment. According to Tissot, semen was an essential fluid that drained vitality and degenerated the mind and body when expelled. Wasting semen was seen to disable organs, cause maladies such as syphilis and gonorrhea (then called social diseases), and be directly responsible for “degenerate promiscuity” and “whoring” (Money & Lamacz, 1989). Tissot fused the social vices of recreational sex, multiple sex partners, sex work, and sex outside of marriage with “the secret vice”—self-abuse (aka masturbation; p. 19). He linked perceived immoral partnered sexual practices with masturbation as the reason why some people degenerated into “whoring” and disease. Without the knowledge of germ theory, he proposed that semen loss from sexual dreams and masturbation, driven by lustful feelings, caused STIs and sexual degeneracy. Most important, Tissot believed lust could be spread to others through coarse, crude, and offensive indecent sexual behavior (lust as a contagion?). Not only were these social diseases believed to be the reason why certain people progressed into states of increasing sexual depravity, they were the etiological explanation for mental illness and sexual disorders. “Degeneracy theory became applied to the explanation specifically of psychiatric and sexological disorders during the middle of the 19th century” (Money & Lamacz, 1989, p. 20).

When nonmarital and nonprocreative sex can lead to psychosis or perversion, it does not take too long for procreative sex within marriage to become the only sexual activity safe from social and medical condemnation. The emerging field of psychiatry identified masturbation, unconventional
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Sexual turn-ons, and recreational sex as symptoms of lustful wantonness that devolved into perverted sexual behaviors. Degeneracy found new life in the words of Freud and his contemporaries. Their medical theory shifted degeneracy caused by immoral wanton lustful fantasies to psychopa-thological regression (which was a step toward compassionate care). Degeneracy was now imbedded in a mental illness manifested by either an arrested development or a regression to an earlier stage of psychosexual maturation. Intrapsychic fixation from an unachieved psychosexual developmental task became the medical explanation for behaviors judged as sexual psychopathy. Sexual degeneracy theory was woven into the fabric of early psychiatric thought, merging mental illness with sociocultural values, and reflected publicly scorned, criminal, religiously condemned sexual desires or behaviors (Money & Lamacz, 1989). We benefit from the findings of modern scientific research that plainly dispute these historical notions of morbidity. These proposals are perfect examples of how sociocultural sexual values are expressed in notions about health and wellness in the absence of empirical evidence. Although we can now easily dismiss the idea that lust causes venereal diseases and organ failure as illogical and incorrect, the concept that sexuality degenerates into a state of moral depravity and physical disability continues to find a home in sexual dysregulation constructs.

The primary focus of our review examines the current professional debate stemming from the sexual addiction framework popularized in the 1980s. Since the inception of the SA framework in The Sexual Addict by Patrick Carnes (1983), differences about etiology and diagnostic criteria for sexual dysregulation remain central to the mental health field and consumer literature. The embedded hypothesis within this framework threads through centuries of conflicting and overlapping approaches (Ley, 2012); although a comprehensive history of the sexual addiction concept is beyond the scope of this book, see Giugliano (2009), Ley (2012), Reay, Attwood, and Gooder (2015a) for a review. Other models to emerge alongside “sex addiction” (SA) include “compulsive sexual behavior” first postulated by Michael Quadland (1985) and further developed by Eli Coleman (1990). In 1987, “sexual impulsivity” was introduced by Barth and Kinder and “hypersexuality” by Martin Kafka (1997), then “dysregulated sexuality” by Winters, Christoff, and Gorzalka (2010), and finally “impulsive/compulsive sexual behavior” (ICSB) an updated revision of Coleman’s compulsive sexual behavior (Coleman, 2011). Despite the emergence of competing models, SA captured the attention of the general public and mental health field. SA became the prevalent model in the consumer literature and, in the late 1980s, a guild of mental health care professionals was formed to promote a new area of therapy specializing
in treating SA. Therapists using the SA model established diagnostic criteria as well as a clinical model of sexual addiction treatment.

Yet, SA specialists did not represent the entire provider community treating sexual behavior problems. Sex therapists, behavioral specialists, sex offender treatment providers, and psychiatrists were also treating clients concerned about sexual dysregulation. These disparate practitioners brought their own competing ideas, conceptualizations, and perspectives to their clinical work and research questions about problematic sexual behavior. Many were neither trained in the addiction field, nor believed that treatment methods linked with addiction were the best course of treatment for these issues. Although everyone was interested in helping clients address their sexual behavior concerns, disagreements about etiology and treatment methods merged with provincial conflicts between professional identities: sex therapist and sex addiction therapist. Thus, affiliation with a professional organization also identified the model of treatment with which these disparate professionals practiced. Sex therapists, addiction treatment professionals, Christian therapists, and generalists gravitated toward the professional organizations that aligned with their models of treatment. Increasingly heated conflicts among these diverse treatment professionals led to a split in the field.

Not only was sexual addiction a term used to label sexual behavior and around which a community of practitioners formed, the movement advocated for the inclusion of “SA” as an officially recognized psychiatric disorder in the Diagnostic and Statistical Manual (DSM; American Psychiatric Association [APA], 1952). It would not be the first time that disorders of sexual excess or dysregulation were listed in the DSM. The first edition (APA, 1952) included “nymphomania” as a diagnosis. It was removed in the second edition (APA, 1968) only to be re-added in the third edition along with “Don Juanism” (APA, 1980). References to nonparaphilic SA were made in the DSM-III-R (1987), but all references to sexual excess or dysregulation were removed in the DSM-IV and only alluded to in the definition for “Sexual Disorder, Not Otherwise Specified (NOS)” (APA, 2000). Seeming to confirm the expression “everything old is new again,” “Sexual Disorder NOS” was removed and “HD” (Kafka, 2010) was proposed and rejected from the most recent edition of the DSM (5th ed.; APA, 2013). HD was not included because of “insufficient peer-reviewed evidence to establish the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders” (APA, 2013, p. 481). Thirty years of theory development that attempted to anchor problematic sexual behaviors to a specific psychiatric disorder, diagnosis, or treatment paradigm has led us to no clear accepted terminology or approach (Joannides, 2012; Kaplan & Krueger, 2010).
Areas Needing Clarity

In this section, we review three predominate models that advance excessive and dysregulated sexual behavior as a specific and distinct psychiatric disorder. Although a discussion about the emerging conceptualizations and diagnostic categories for out of control sexual experiences provides excellent material for professional debate, that is not our intention. Our objective is twofold:

1. To illustrate the limitations of the prominent models that motivated the development of our treatment protocol
2. To provide a clinical guide for therapy interventions in an era when therapists are faced with complex sexual problems and the psychotherapy field is deeply divided about whether to even call this issue a disorder

Sexual Addiction

Probably the most popular label used by the general public and the term that sparks the most contention among physicians, psychotherapists, sex therapists, and sex researchers is sexual addiction. In The Sexual Addict (republished as Out of the Shadows in 1994), Carnes defines addiction as “a pathological relationship with mood altering experience” (Carnes, 1983b, p. 4) and links sex to the experience that alters mood. He suggests using the SAFE formula to discern addictive from nonaddictive sexual behaviors. Sexual behavior is addictive if it is (S) secretive, (A) abusive to self or others, (F) used to avoid painful feelings, and (E) empty of a caring or committed relationship. He later adds 10 signs that indicate SA and 10 behavioral types (Carnes, 1991). Other researchers and theorists have amended or expanded the definition of sexual addiction. Schneider and Irons (2001) indicate three elements can be used to create an operational definition for any behavioral or chemical addiction: (1) compulsivity, (2) continuation despite harmful consequences, and (3) obsession or preoccupation with the activity. Weiss (2013) describes sexual addiction as “a dysfunctional preoccupation with sexual urges, fantasy, and behavior, often involving the obsessive pursuit of non-intimate sex, pornography, compulsive masturbation, romantic obsession, and objectified partner sex” (p. 1). Magness (2013) defines sexual addiction as a “progressive intimacy disorder” of patterned destructive sexual thoughts or behaviors the person is unable to stop. Other theorists and researchers apply problematic sexual behavior to the substance dependence criteria of the corresponding DSM edition of the time (Goodman, 2001; Sealy, 1995; Wines, 1997).
Neuroscience and biophysiological research are emerging fields of study seeking to validate the behavioral addiction construct. Gambling disorder was included in the DSM-5 in the “substance-related and addictive disorders” section as the only nonsubstance disorder. The inclusion of this diagnosis reflects the “evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse and produce some behavioral symptoms that appear comparable to those produced by the substance use disorders” (APA, 2013, p. 481). Sexual addiction is among the many life preoccupations that theorists consider a behavioral, process or “natural” addiction (D. L. Hilton, 2013). D. L. Hilton (2013) draws on current understanding of pathological gambling and “food addiction” to support his hypothesis that a comparable mechanism underlies sexual addiction. Sexual behavior is seen as a powerful form of reward-based learning. He proposes that repeated viewing of sexual imagery alters neural receptivity and pathways that lead to observable behavioral change. Clinicians and researchers who endorse the SA framework are looking toward neuroscience to establish the etiology of SA with a particular focus on “pornography addiction.” D. L. Hilton (2013) believes the contemporary understanding of neuroplasticity and the DSM-5 inclusion of gambling disorder foretell the inclusion of SA as a biological and behavioral diagnosis. However, he concedes, “there is, of course, a lack of comparable functional and behavioral work in the study of human sexual addiction, as compared to gambling and food addictions” (p. 2). Reid, Carpenter, and Fong (2011) critique this biobehavioral foundation for SA. They state that there is no agreed-upon standard of what constitutes an addiction (which makes obtaining evidence of a sexual addiction challenging) and that assertions without similar studies within human sexual behavior are “speculative and unsupported” (p. 4). They add a cautionary note that the addiction model may limit our understanding by offering an overly simplistic view of the diverse issues encountered by this clinical population. There is little systematic research dealing directly with sex as an addiction and the epidemiology and treatment literature is “primarily anecdotal in nature” (Giugliano, 2009, p. 16).

**Impulsive/Compulsive Sexual Behavior**

ICSB is a “clinical syndrome characterized by the experience of sexual urges, sexually arousing fantasies, and sexual behaviors that are recurrent, intense, and a distressful interference in one’s daily life” (Coleman, 2011, p. 376). People concerned about ICSB identify their behavior as
excessive and struggle to stop. Coleman indicates that he prefers this term because of its descriptive nature and that it provides room to incorporate multiple pathological pathways and treatments. As the name suggests, sexual symptoms are seen as impulsive or compulsive, distinguished by the underlying motivations driving the behavior. Impulsive behaviors are intended to feel pleasurable, whereas compulsive behaviors intend to prevent or reduce subjective discomfort. These characteristics can also be seen in the sexual addiction model, but ICSB does not include the concepts of withdrawal or tolerance, which bedevil sexual addictions theorists (Giugliano, 2009).

ICSB distinguishes between two types: paraphilic and nonparaphilic. The primary difference is the former involves sexual behavior considered deviant and the latter involves normative behavior. Within each type are behavioral subtypes: paraphilic ICSB includes the paraphilias identified in the DSM-5 and nonparaphilic ICSB subtypes. Coleman also proposes a sexual behavior continuum from healthy/problematic to impulsive/compulsive. A diagnosis of ICSB is made when sexual behaviors cross a threshold from problematic to impulsive/compulsive as determined by the provider. Because there is currently no clinically validated measure to diagnose ICSB, Coleman recommends using established psychiatric and medical diagnosis procedures and gathering a sexual history to determine the threshold for ICSB. Coleman acknowledges that the threshold between problematic sexual behavior and ICSB is subjective and that there is a potential risk of diagnosing both healthy and problematic sexual behaviors as pathologically disordered. He attributes insufficient clinician training as well as client and/or therapist disapproval of diverse sexual fantasies and sexual activities as significant factors in misattributing sexual behavior as ICSB (Coleman, 2011).

Hypersexual Disorder

HD is a sexual-desire disorder characterized by recurrent and intense sexual fantasies, urges, or sexual behaviors (Kafka, 2010). Motivations underlying hypersexuality are associated with relieving dysphoric emotions and experiencing multiple unsuccessful attempts to limit or control the amount of time spent engaging in sexual thoughts, urges, or behaviors. Kafka (2010) drafted the proposed disorder criteria for DSM-5 with established medical and psychiatric terminology used in other sexual-disorder diagnoses. HD also includes the familiar psychiatric diagnostic threshold of time spent, response to dysphoric moods or stressful life events, unsuccessful efforts to control or reduce sexual symptoms, and
engaging in sexual behaviors despite adverse consequences. As with sexual addiction and ICSB, HD delineates subtypes of sexual behavior such as masturbation, cybersex, or strip clubs.

Kafka (2010) suggests that there is sufficient data to consider HD a sexual disorder, one with both compulsive and impulsive features, or to classify it as a behavioral addiction. He advocates for clinical criteria that can incorporate dimensions across differing clinical samples and incorporating differ pathological pathways. Researcher and clinician Rory Reid has been instrumental in examining etiology, prevalence, and treatment of HD. He acknowledges the infancy of HD research and the need for more studies to clarify HD criteria. At this time, “little is known about the onset, clinical course, and trajectories of HD symptoms as they manifest in various populations and across gender” (Reid, 2013, p. 13). Moser (2013) cites Kafka’s (Kafka & Hennan, 2000) research, suggesting that the treatment of co-occurring psychiatric disorders may often ameliorate the sexual symptoms and should be the preferred diagnostic frame used instead of “branding” clients with a disorder that can only be put in remission but not resolved.

Common Clinical Concerns With Existing Models

Before we can introduce our OCSB conceptual framework, we want first to clarify and discuss general topics and areas of clinical concern that are common within sexual dysregulation diagnoses.

Sexual Behavior Classification

Identifying clinical subtype classifications based on specific sexual behaviors or actions is a common feature among the proposed dysregulated sexual behavior diagnoses. Thus, observable sexual behaviors that share some common actions are either organized or diagnostically labeled based on their common features. The behavioral subtypes are all incorporated within a primary disorder of dysregulated sexual behavior. The categories do not identify distinct etiologies, but rather provide specificity for assessment and treatment. In our review of the literature, we found three general groupings for classifying sexual behavior problems. In one category, the specific sexual activity includes entertainment practices such as erotic literature, nongenital contact at strip clubs, and watching sexual videos. A second category centers on partnered sexual activities, including anonymous partners, multiple partners, pursuing sex partners, sex in bathhouses, or unconventional turn-ons. A third group focuses on sexual
behavior symptoms that either violate (through dishonest or exploitive deception) or are nonconforming with traditional sexual monogamy (either honestly or deceptively) within marital or relationship agreements. Common behaviors within this category are love affairs, one-night stands, genital contact at strip clubs, paying for sex, as well as unacceptable masturbation practices within the couple’s agreement.

Is the specific sexual activity or context a useful or clinically pertinent factor for diagnosis? No other clinical disorder includes typology based on specific behavioral symptoms. At this point, eating disorders do not require the clinician to identify behaviors beyond the restrictive or binge/purge behavior patterns. There are currently no subgroup clinical distinctions like group binge eating or solo binge eating (compulsive masturb-eating?), food-specific binge eating (e.g., desserts, snacks, or quinoa), or deviant eating patterns (e.g., only eating protein supplements, pathological use of the Paleo or Atkins diets). Pathological gambling does not currently include categories like online gambling, casino gambling, or compulsive lottery-ticket scratching. Furthermore, any categories that involve technology quickly become dated. Look at how phone sex has evolved in the past 10 years. Is sexual webcaming considered phone sex or online sex behavior? And, for diagnostic purposes, does it really matter? To be clear, we do agree with the value of assessing the sexual behavior details to develop the client’s Unique Clinical Picture as well as to establish an effective treatment plan. However, delineating sexual behavior subcategories risks assuming a common etiology links these behaviors when they may be caused by unrelated phenomena (Cantor et al., 2013). Not to mention how the mere act of labeling specific sexual behaviors as diagnostic subcategories risks conflating unconventional or socially unacceptable sexual behaviors with pathology.

**Nonconsensual Sex**

Established SA therapist certification standards do not distinguish treatment approaches between consensual and nonconsensual sex. It is unclear under what circumstances CSAT may exceed their scope of practice in treating nonconsensual sexual behaviors. The professional literature is also unclear concerning when a therapist should refer a client to a nonconsensual sexual behavior specialist; also, the standards for treating nonconsensual sexual behavior within the current sexual dysregulation models remain underdeveloped.

In 1991, when developing his out of control behavior therapy specialization, Doug received referrals from San Diego psychotherapists who not did think their male clients with problematic consensual sexual
behavior were a good fit for participating in therapy groups with sex offenders. Men concerned about their excessive masturbation or partnered sexual behaviors were sitting in group therapy with men who were arrested for sex crimes, who had engaged in child molestation or nonconsensual public sexual exposure. When formulating his own treatment group, Doug considered the potential impact of mixing these populations within his future groups. Would men engaged in consensual sexual behavior benefit from a group that includes men who engaged in nonconsensual, illegal, or predatory sexual behavior? Or, are the treatment strategies for consensual and nonconsensual sexual behaviors different enough that a mixed group is not the best approach?

In 1993, Doug decided that his outpatient psychotherapy group and individual OCSB treatment program would only treat clients concerned about consensual sexual behavior. This meant men with a history of rape, sex with minors, exhibitionism, voyeurism, and frottage would be referred to nonconsensual specialists for further assessment and treatment. Of course, not all sexual behaviors fit easily into the consent/nonconsent binary. For example, Bill, a 42-year-old gay Californian, living with his husband of 5 years, wears wide-leg shorts without underwear to his gym. He is preoccupied with men glancing at his legs and being able to see his penis. When he returns home, he remembers their faces and masturbates to these visual images. He has never disclosed this behavior or that this is a peak erotic turn-on. Omar is a 37-year-old heterosexual man married for 12 years with two children. He has been taking women’s underwear from dirty-clothes hampers in family and friends’ homes since he was a teenager. During masturbation, he touches and smells the underwear and ejaculates on them and then puts them in the trash. During a recent social gathering, he was discovered taking underwear from a neighbor’s bedroom hamper. Clients who report nonconsensual sexual behaviors require a clinical assessment to determine the most effective course of treatment. What is first disclosed should not be assumed to be the full breadth of the historical or current nonconsensual behavior. We address the role of consent/nonconsent in the OCSB protocol in Chapters 2 and 5 on sexual health principles and the screening procedure, respectively.

Paraphillic and Nonparaphillic Sexual Disorder

The mental health field has historically identified that non-normative sexual interests and behaviors are clinical disorders. Both deviancy and sexual dysregulation involve sexual behaviors and interests that are persistent, problematic, and frequently at odds with an individual’s
values, ethics, or desired self-image. Paraphilia is the current conventional medical term used to describe sexual behavior and arousal patterns that deviate from social norms (Bancroft, 2009). The Greek root of the prefix para means “besides,” and, when added to the base word, indicates an abnormality. Together with philia, an ancient Greek word meaning “love” or “friendship,” the term paraphilia can be understood as “outside of normal love” or “abnormal love.” The history of the medical term paraphilia dates to the early 20th-century psychoanalysts and writers Wilhelm Stekel and his protégé, Benjamin Karpman (Money & Lamacz, 1989). The term was first introduced into the DSM-III in 1980 replacing the term perversion.

Paraphilia’s definition was expanded at the end of the last century by sex researcher John Money (1999). He proposed a developmental process that rooted the origins of paraphillic sexual functioning within prepubertal antecedents. According to Money (1999), the forerunners of adolescent and adult paraphilias were to be found in threatened or actual childhood abandonment, separation, or loss in early life. These adverse childhood experiences influenced childhood sexual development by creating a need for a psychological splitting between relational attachments and sexual behavior or erotic imagery. Money (1999) explains paraphilia as an individual’s triumph in salvaging his or her intense bodily sexual arousal, pleasure, and desire from the wreckage of derailed childhood developmental processes. He coined the term lovenmap to describe the resulting personal schema of this compromised yet effective solution to keep both one’s capacity to love and to experience sexual excitement.

The current DSM-5 diagnostic criteria for paraphilic disorder emphasize Money’s early distinction between a major pathological paraphilia (those listed in DSM) and a minor playful sexual variant. The DSM-5 (APA, 2013) defines paraphilia as “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners” (p. 685). To receive a paraphilic disorder diagnosis, the paraphilia must cause distress or impairment to the individual or, if the paraphilia is personally satisfying, the specific sexual behavior does not entail personal harm or risk of harm to others. One can now have a paraphilia without meeting criteria for a clinical disorder.

The establishment of paraphilic disorder was not without controversy. Moser (2011) deconstructs the definition to illustrate how psychiatric diagnostic criteria do not reliably differentiate between paraphilic and normophilic conditions. For instance, is an intense and persistent sexual interest in surgically enhanced breasts or shaved hairless bodies considered “phenotypically normal”? Does a preference for being whipped rather than
engaging in coitus constitute a paraphilia, whereas being whipped as foreplay to coitus is subsumed under normophilic criteria? He also observes the sexism evident in paraphilia evaluation when a woman wearing silk panties to feel sexy is privileged over the same behavior in a man. “It is possible that a scientific distinction between paraphilia and normophilia does not exist—only one based on shifting societal norms” (Moser, 2011, p. 484). Philosopher Robert Scott Stewart writes about the last century’s focus on normative or perfectionistic sex as reciprocal, affectionate, and interpersonal and how these same values and normative standards remain the clinical thresholds for demarcating sexual perversions, paraphilias, and sexual disorders (Stewart, 2012). It is deeply problematic when failure to reach these socially constructed ideals is defined as a mental illness or sexual disorder.

Distinctions between paraphillic and nonparaphillic traits in dysregulated sexual behavior vary depending on the model’s current iteration. For example, the language of paraphilia is nonexistent in early sexual addiction writings. The framework describes three levels of deviancy described as culturally acceptable sexual behavior; nuisance sexual behavior; and dangerous, abusive, or life-threatening behavior. These categories are descriptive of progressive levels of risk, not progressive stages of addiction (Carnes, 1989). In this model of deviancy, what might be called paraphilic is instead organized around a person’s escalating level of sexual risk-taking behavior. In this conceptualization, no distinction is made between paraphillic and nonparaphillic behavior, rather the diversity of paraphillic behaviors is viewed through the lens of cultural acceptance/violation, legal consequences/risks, victimization, and degree of public dislike or outrage.

Separating paraphillic and nonparaphillic sexual behaviors has been discussed in the development of HD (Kafka, 2010; Reid & Kafka, 2014) and ICSB (Coleman, 2011). Although they conclude that the similarities between the paraphillic and nonparaphillic types of problematic sexual behavior far outweigh the differences, both Kafka and Coleman focus on the degree of deviance or unconventionality that are specific to paraphilia.

A Profession Divided

It is understandable why a consensus has yet to materialize regarding the etiological mechanisms or the establishment of a dysregulated sexual behavior disorder. The factors that contribute to sexual behavior problems are diverse and multivariate, and intertwined within a range of sociocultural influences and biopsychological factors. Over time, these models have gained prominence and undergone scrutiny in scientific and nonscientific
venues, from peer-reviewed journals and conference presentations to blog posts and talk shows. SA is the prominent model in the consumer literature and a specific certification process has been developed around it. Sexual addiction is frequently the construct used when sexual behavior problems are discussed or criticized in the media, churches, courtrooms, hospitals, and therapy offices. Proponents of an SA, ICSB, and HD diagnosis critique the limitations, biases, or etiological mischaracterizations of the other models or opposing perspectives. Thought leaders presume the superiority of their conceptualization with a confidence unsupported by the accumulated scientific evidence and discussion between fellow practitioners devolves into rigid defensive postures at the expense of complex professional dialogue and critical thinking. As if it is not already difficult to discuss the wide array of client sexual problems among peers, discussions between colleagues devolve into rigid discourse in which professionals defend their positions at the expense of complex critical thinking. As practitioners in the field and consumers of the literature, we are discouraged by the tension that prohibits open dialogue about OCSB.

Charles Samenow, editor of the Journal of Sexual Addiction and Compulsivity, in an opening editorial for a volume that focused on HD, stated, “although there remains no unified model for what we and our clients call sex addiction, I think in reviewing the research presented in this journal one can only conclude that the similarities between the constructs and different research continues to outweigh the differences” (Samenow, 2013, p. 1). Samenow recommends that the “work must include developing grounded theories, research to illuminate the biological and neurochemical mechanisms associated with problematic sexual behaviors, and outcome research to find effective treatments (both pharmacological and psychosocial) to relieve the pain and suffering associated with this phenomenon” (p. 2). Samenow’s introductory comments strike a professional collaboration tone. It is admirable to read his message in a journal dedicated to sexual addiction and compulsivity research in a special issue specifically examining HD research.

Most important, many of the current psychotherapists and researchers are united by their common interest in improving clients’ lives. It is easy to get mired in debates about etiology, the latest fMRI research, or the perceived sex-negative cultural values in sexual dysregulation models. Frequently lost in the debate is the acknowledgment that, in the three decades since the term “sex addiction” was popularized, the benefits of the various treatment models coexist with their weaknesses. The main benefits include:

- A common language used to discuss the diverse range of behaviors under the umbrella of “sex addiction.”
Dysregulated sexual behavior shifted from a source of moral judgment and rejection associated with promiscuity to a medical problem allowing people access to treatment and empathy.

The development of the HD diagnostic criteria (Kafka, 2010), which enabled the recent scientific inquiry for inclusion in the *DSM-5* (Reid et al., 2012).

Here are the main costs and limitations we have seen in practice or identified in the literature:

- Sexual addiction, ICSB, and HD risk reinforcing sociocultural disapproval of specific sexual behaviors (M. P. Levine & Troiden, 1988; Ley, 2012; Moser, 2013; Reay, Attwood, & Gooder, 2015b).
- Failure to behave within concepts of normative or conventional sex is defined as a sexual disorder (Stewart, 2012).
- SA carries the historical burden of labeling the adjustment symptoms of sexual identity development for gay and bisexual men as an addiction.
- Nonconsensual sexual patterns are inappropriately subsumed within SA, ICSB, and HD criteria.
- Sexual dysregulation appears in those reporting higher levels of sexual desire and it is unclear whether the additional features of proposed disease models add any explanatory power (Steele, Staley, Fong, & Prause, 2013; Winters et al., 2010).
- Data demonstrating that SA, ICSB, and HD are distinct mental disorders are lacking (S. Levine, 2010b; Moser, 2013; Reid, 2013).
- Prematurely framing a sexual problem as a clinical disorder pathologizes normative behavior, affects the individual’s self-concept, and invites overly restrictive sexual interventions.
- Creating a disorder for sexual dysregulation or sexual excess risks mental health professionals inadvertently inducing symptoms related to that disorder (i.e., an iatrogenic illness; Bancroft & Vukadinovic, 2004; Giugliano, 2004).
- The popularization of the SA model has created a meme in the general public in which sexual behavioral problems are routinely evaluated through the lens of addiction despite the lack of scientific consensus.

We share S. Levine’s (2010b) hope that the field may be ready to reexamine the concepts of sexual dysregulation disorders and no longer confuse the “utility in getting people into treatment with the validity of the idea that the men have a discrete disorder” (p. 274).
OUT OF CONTROL SEXUAL BEHAVIOR—A SEXUAL PROBLEM

S. Levine (2010a) organized sexual difficulties on a spectrum from worries to problems to disorders. Sexual worries are common, almost universal concerns people have about their sexuality that only reach an intensity level of distraction. Worries are the most frequently occurring sexual difficulty because they are “concerns that are inherent in the experience of being human” (S. Levine, 2010a, p. xi). Examples include: When will I have my first intercourse? Will my partner be less attracted to me if I am bald? Does my vagina smell funny? Is it normal to be less interested in sex now that I am breastfeeding? Sexual worries are unavoidable and evolve over the life span.

On the other end of the spectrum, sexual disorders are the most frequently studied and least prevalent of all sexual difficulties. These include the officially recognized medical and psychiatric diagnoses such as erectile dysfunction, vaginismus, or premature ejaculation. Despite their lower prevalence rate, sexual disorders are assumed to be more prevalent than health care professionals diagnose and have the greatest potential to disrupt one’s life (S. Levine, 2010a). Sexual problems fall between common sexual worries and discrete sexual disorders. They are a source of suffering that afflicts groups of people, but attract little research due to the varied contributing factors and underlying causes inherent in sexual problems. Furthermore, “what is regarded as ‘problematic’ sexual functioning may be normative in a different cultural context” (K. Hall & Graham, 2013, p. 1). When evaluating the lens through which we label sexual behaviors as problematic, the role of sociocultural values is essential to consider. Western societies centered in Western Europe, Britain, Canada, and the United States have conducted most of the treatment research for sexual problems (K. Hall & Graham, 2013). Unfortunately, this means much of what is understood to be generalizable sexual problems may too often be a culturally defined problem. What is understood as normative in one culture can often be highly stigmatized in another. Social mores and stigma related to sexuality may skew statistical information gathering that informs sexual-disorder definitions (Giugliano, 2004). Sexual orientation, termination of pregnancy, differing levels of desire between couples, and notions of sexual pleasure in some contexts are sexual problems and symptoms of pathological disorders in others.

To understand the line between sexual problem and disorder, Bancroft and Vukadinovic (2004) pose a question that theorists and researchers have not answered: Is OCSB a problem on the extreme end of the “normal” range of sexual behavior or is it a distinct behavior that
is “qualitatively different from the norm in ways that are problematic” (p. 225). We believe their recommendation remains an important contemporary position: It is premature and perhaps iatrogenic to establish a sexual dysregulation clinical disorder and instead we recommend using the phrase “out of control sexual behavior.” Therefore, until such time that evidence supports the establishment of a sexual disorder, we view OCSB as a problem within the normal range of human sexual expression. We believe if disordered levels exist, they are extremely rare, comprising a much smaller segment of the men seeking treatment for OCSB.

We define OCSB as a sexual health problem in which an individual’s consensual sexual urges, thoughts, or behaviors feel out of control. Some client symptoms may fit criteria of the previously discussed disorder proposals, but we are more interested in exploring the client’s subjective experience. Men may report feeling out of control regularly or in different situations. Onset may be recent or decades in the past. We invite you to think of “out of control” as an expression of an individual’s subjective experience. It is a personal description of the various sensations, thoughts, perceptions, and emotions contributing to their sexual behavior problems. Marty Klein (2012) makes a subtle, but significant distinction about this definition: feeling out of control is different than being out of control. It is unlikely that the client is pervasively without the ability to direct his sexual behavior. However, clients are communicating an affective experience that feels like they lack agency during certain sexual situations.

It is important to clarify our use of language. We define OCSB as a sexual health problem in which an individual’s consensual sexual urges, thoughts, or behaviors feel out of control. Rather than repeating “out of control sexual urges, thoughts or behavior,” we condense the string of words to OCSB or out of control sexual experiences. We are not excluding urges and thoughts when referring to OCSB. We also use the phrase “problematic sexual behavior” or “sexual behavior problems.” Problematic sexual behaviors are behaviors that generate significant negative consequences, but the phrase is not meant to infer a felt sense of being unable to control sexual thoughts, urges, and behavior. In short, OCSB is likely problematic, but not all problematic sexual behaviors are considered OCSB. Problematic sexual behavior is usually discussed during the early stages of an assessment as we are clarifying the client’s subjective experience.

Areas of Distinction

Several areas differentiate OCSB from the three primary models. HD, ICSB, and sexual addiction stem from a proposal that considers sexual dysregulation as a clinical disorder (e.g., psychosexual disorder or addictive
disorder). HD and ICSB assume multivariate pathological pathways and SA assumes one etiological mechanism. With OCSB, we contextualize all sexual behavior within a general theory of human behavior. As with all behaviors, various factors influence a person’s ability to satisfactorily assert control or feel satisfied in his choices and behaviors. Pathological pathways may contribute to OCSB as various clinical disorders have sexual consequences. We organize the various factors that contribute to a client’s sense of feeling out of control, including established clinical disorders, personality traits, adverse experiences, and chemical dependency that has sexual symptoms. But, not all vulnerability factors are disordered pathways. As a result, we identify various vulnerability factors that contribute to OCSB. We consider the role of motivations that compete with sexual health and how these competing motivations create an internal struggle that affects self and attachment regulation and sexual/erotic-identity development. In our practice, we conduct a comprehensive assessment that leads to constructing each client’s Unique Clinical Picture, which guides treatment planning and recommendations.

An empirically informed approach and clearly developed concept of sexual behavior problems are necessary to ensure quality treatment when faced with the sexual-disorder meme and sexuality misinformation, which overly influences the therapeutic interaction. Along with our OCSB definition and clinical model, we propose a sexual health assessment and treatment pathway to guide psychotherapy. One important disclaimer: Our OCSB conceptualization and protocol is currently limited to men. They are the primary demographic who present for sexual dysregulation in the United States and this model reflects our collective clinical experiences over the past 20 years. The OCSB conceptualization and protocol can inform a therapist’s approach with women, but, as practitioners, we are currently not in a position to construct that bridge.

**Consensual Sexual Behavior Problems**

The OCSB Model makes a clinical distinction between nonconsensual sex and paraphilias. The OCSB protocol encourages clinicians to investigate possible sexual- and erotic-identity obstacles and propose “sexual and erotic conflicts” as one of three clinical areas for investigation and clinical response. We are interested in identifying the degree of “fixatedness” in a client’s arousal pattern. OCSB treatment facilitates positive sexual- and erotic-identity development by integrating the man’s arousal patterns into his self-concept. If a sexual or erotic conflict is present and involves a rigid arousal pattern, the goal of therapy is to expand a man’s range of arousal and integrate his turn-on within his sexual or erotic identity.
This clinical emphasis on integration of erotic orientation within men’s sexual lives is one of the reasons why clients with nonconsensual sexual urges, thoughts, or behaviors are excluded from OCSB treatment. This clinical distinction leads us to refer these individuals to nonconsensual specialists who are capable of assessing and treating men with nonconsensual sexual behavior and to provide the treatment interventions that differ from clinical work for men with consensual sexual behavior problems. In Chapter 5, we discuss how we assess and refer men who report nonconsensual sexual behavior.

**Self-Discrepancy, Not Personal Distress**

Client personal distress about sexual behavior is another clinical distinction within OCSB treatment. There is a clear segment of the population who report distress because of their sexual behavior. The reason you may be reading this book is that you have met with clients distressed about their sexual behavior. We began this chapter by introducing a range of clinical situations in which one or more people bring their distress to a professional. It is often a sudden client sexual crisis that precipitates a request for help. Each of the three proposal diagnoses, sexual addiction, ICSB, and HD, include aspects of personal distress either in its diagnostic criteria or clinical descriptions. Coleman (2011) indicates that people must reach a level of clinical distress to meet criteria for ICSB. Clinically significant distress or impairment in various areas of life is a criterion for HD (Kafka, 2010). The absence of distress does not preclude an HD diagnosis as long as personal impairment, occupational impairment, or social impairment is demonstrated. The role of distress in SA is more difficult to ascertain. Sexual addiction in its most basic definition focuses on a pattern of sexual behavior that causes problems in someone’s life. The distress may be twofold, as an emotional consequence of the sexual behavior as well as the inability to reliably stop the pattern of behavior as a response to negative consequences (P. Hall, 2013).

The definition of OCSB intentionally excludes the mention of personal distress. We are interested in highlighting the concept of behavioral control and client motivation for change. We are less focused on a clinical threshold of distress to establish a psychiatric disorder in order for the client to access treatment. Client distress may be related to the external disapproval, disgust, or conflict about sexual behavior rather than the client’s felt sense of his sexual control. Personal distress does not mean the same thing as a self-discrepancy about one’s sexual urges, thoughts, or behavior. Clients may be distressed because their partner is upset about their masturbating with sexual imagery. Or, distress may arise out...
of unreasonable expectations or standards about sexual desires. These situations may cause a client distress, but may not motivate him toward sexual health. We focus on the individual’s internal conflict and self-discrepancy when assessing sexual behavior problems and determining whether to recommend treatment. Because OCSB outpatient therapy focuses men toward changing their sexual health, we are more concerned about motivation for health behavior change than an arbitrary level of clinically significant distress.

No Sexual Behavior Categories

Finally, the OCSB Model and protocol eschews clinical sexual behavior subcategories. Instead, the OCSB protocol focuses on behaviors that violate sexual health principles (discussed in the following chapter). We believe categories based on specific sexual activity codify sociocultural sex negativity within the clinical models and privileges conventional sexual behavior as “healthy.” By framing our OCSB protocol in a sexual health paradigm and grounding our conceptualization in a general theory of human (rather than a disease or disorder) behavior, we strived to create a less shame-based sexual behavior organization to help men change their self-discrepant sexual behavior.

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