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A Brief Summary of Assessment and Treatment Issues for Compulsive Online Sexual Activity

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Learning Objectives:
After studying this article, the reader should be able to:

1. Understand the similarities and differences between sexual compulsivity and sexual addictions.

2. Comprehend the characteristics of sexual compulsivity acted out on the Internet.

3. Recognize the fundamental of screening for sexual compulsivity acted out on the Internet.

4. Understand the fundamental treatment components of sexual compulsivity.

Abstract
This article will briefly summarize the salient issues in the assessment and treatment of compulsive online sexual activity. These sexual behaviors can be "obsessive and compulsive, can appear to have many of the qualities we associate with addiction, and may be censored or tolerated by society" (Golden 2001). Kafka (2000) has distilled the facets of hypersexuality into a united taxonomy that categorizes these behaviors into two subtypes: 1) paraphilic, which are generally socially censored and considered illegal behaviors; and 2) non-paraphilic hypersexuality disorders or paraphilia-related disorders (PRD) for those behaviors which are legal and not socially sanctioned. The line between legal and illegal is a fragile one.

This discussion will refer to behaviors which are sexually compelling or hypersexual and are called, in the popular parlance, "sex addictions." There are some important differences between sexual compulsivity or hypersexuality and addiction to substances. From a psycho physiological, intra psychic and social point of view, sexual compulsions manifest themselves differently than addictions to substances (see Goodman, 2001 for a thorough discussion of these terms).

ooper, Scherer, Boies, and Gordon (1999) characterize online sexual activities as driven by a Triple-A Engine: Accessibility, Affordability, and Anonymity. These are characteristics that one would not apply to other types of addictions. Addictions associated with alcohol and substances often have immediate and negative social, public and relational consequences and can cause illness and even death in some instances. Alcohol and substance abuse are not tied to the same psychophysiological rewards of erotic arousal and pleasure in the same way as online sexual activity does (Perelestien, Lipper and Friedman, 1991).

It appears that these sexually compelling behaviors have powerful hidden reinforcers that seem to override the guilt, shame and humiliation that often arise after the erotic behavior is acted upon. The real threat of loss of family, employment or licenses also do not inhibit these behaviors. Furthermore, because many of these sexual behaviors are often hidden for years, they do not have the immediate censure that other addictions may have when they occur. Obsessive masturbation, for example, can be done secretly and with the advent of the Internet and telephone sex, there are, almost daily, new ways to give vent to erotic attachments to impersonal and objectified sexual encounters.

While online sexual activities are intrinsically free of the risk of disease and may be hidden more easily than other addictions, they bring other risks with them. An escalating dependence can evolve that will interfere, not only with pair bonding and employment,

but with other aspects of a satisfying lifestyle. These behaviors also may escalate and eventually lead to contacts off line that will expose a person to risk of contracting sexually transmitted diseases (Kafka 2000). Furthermore, until they are discovered, they do not appear to be problematic to the person who is engaging in them. The illusions provided by denial may have been in place for many years (Golden, 2001).

Assessment Considerations:
The subtleties and nuances of paraphilia-related disorders (PRD) involving the Internet are often masked in a routine mental health evaluation or may masquerade as something else entirely. A few common presentations, for example, may be marital discord due to the seeming hyposexuality of one partner when the other partner may be hypersexual, problems with intimacy, attachment disorders, alcohol and/or substance abuse or depression and anxiety. When a thorough history is pursued by a skilled therapist, it may well reveal a case of sexual compulsivity. Comorbid psychiatric disorders commonly occur with PRDs and it is essential to the long range success of treatment to understand their contribution to the PRD and to treat them as well (Kafka, 2000).

It is necessary for therapists to understand the degree of compulsivity when making an assessment. Internet sexuality, like other forms of sexuality, is best viewed as falling along a continuum ranging from life-enhancing to problematic (Lieblum, 1997; Cooper, Scherer, Boies, & Gordon, 1999). Cooper, Putnam, Planchon, and Boise (1999) identify three types of users:

1. Recreational Users: self-limited, occasional, non-pathological or educational use, not likely to habituate.

2. Sexual Compulsives: individuals who already have sexually compulsive traits and may have a well stablished pattern of unconventional sexual practices as well as a fair amount of dysfunction in their lives.

3. At Risk: individuals with no history of sexual compulsivity but who can have problems due to online sexual pursuits.

There are two subtypes of at-risk users:
a. Depressed: use to elevate mood, may habituate.
b. Stress reactive: users during high stress periods as an escape, use decreases when stress lessens and usual coping skills can be used.

Whether the referral to a therapist is self-initiated, is made by a family member or perhaps a friend or employer, it usually represents a crisis. The secret is out. The sexually compulsive person typically feels quite out of control and perhaps in danger of slipping into illegal behavior or of acting out fantasies with people they have met online. Research has demonstrated that people who meet with partners they find online expose themselves to the possibility of contracting a sexually transmitted disease (McFarlane, Vull, & Rietmeijer, 2000) including HIV (Toomey & Rothenberg, 2002). They often may be in danger of being divorced as well as being fired from their job or losing a professional

license. “While in fact these behaviors may not be illegal, it seems to the people involved that a major loathsome crime has been committed when these behaviors are uncovered. Partners often discover and ‘blow the whistle’ on these behaviors and react with the same sense of zero tolerance associated with the discovery of a major criminal act (Golden, 2001).”

Guidlines are emerging for assessment and treatment of sexual compulsivity attached to the Internet (Cooper, Scherer, Boies, & Gordon, 1999; Delmonico, 1997). The evaluation process may take place over several months and typically blends with the beginning phase of treatment. Containment of the sexually compelling behavior begins during the evaluation phase, especially when the client or others who may be involved are at risk. While it is best to have the assessment done by a therapist who is experienced in this field, the resources in many communities may be scarce or non-existent. There also may be problems with anonymity in a rural community. A fair amount of sophistication and experience needs to be brought to the evaluation because secrecy has become a way of life for these clients, and for many it is characterological. The person may also be at risk for suicide because of what is brought to light, so there must be attention to the pace with which the details are revealed. Unlike other sexually compelling behaviors, with Internet addiction, the exposure to sexual content can be far beyond the usual material the average therapist may be familiar with. The specific details of the sexual behaviors are important to uncover as the therapeutic alliance is developed, but the first order of business is to contain both the crisis and the behaviors. We would recommend using some of the currently available questionnaires (See Delmonico, Griffin, & Carnes, 2002) if the therapist is inexperienced and/or reticent to elicit details or ask questions about sexual issues. It is important to note that “assessment instruments cannot replace the personal interaction and clinical judgment of a trained therapist” (Delmonico, Griffin, & Carnes, 2002).

It is also essential to include the partner or spouse, and perhaps even the family, at some time during the initial evaluation process for many reasons. First of all, it serves to assess the emotional state of the other important people in the person’s life who are also deeply affected and who often feel egregiously betrayed. “Couple therapy can help an individual see her or his partner as a source of support instead of an obstacle and vehicle for projected shame and self-hatred” (Cooper, Putnam, Planchon, & Boies, 1999). Because the sexually compulsive client may be in denial about what is happening, the partner or spouse can also provide data to aid the therapist in more fully understanding the problem and its impact on the family. Both people own the same sex life and relationship. Sharing information and psycho educational materials as well as recommending an individual therapist for the partner and/or family is helpful in the beginning of an assessment. It is also good practice from the point of view of developing rapport, organizing a treatment team, containing the crisis and providing a “safe holding environment” within which treatment can begin.

A necessary part of any mental health evaluation is to assess what role psychotropic medications would have in treatment and this is certainly crucial for people with online sexual compulsivity. Serotonergic medications have become an accepted part of the

treatment regimen in these cases (Stein, et. al. 1992; Kafka, 2002). Even if the primary therapist may not have a license to write the prescription, she or he needs to be familiar with psychotropic medications and how they can be helpful. Keeping in mind that a psychiatrist familiar with the issues may not be readily available in some places, a family physician may need to write the actual prescription and need the consultation of the therapist in dealing with the client. In addition, while medication may be needed for the sexual compulsivity itself, there may be comorbid states that also need to be factored into the assessment. "In the few studies that systematically evaluated Axis I diagnoses in 'sexually compulsive' males and females (Black, Kehrberg, Flumerfelt, & Schlosser, 1997) or paraphilia-related disorders (Kafka and Prentky, 1992; 1998), one of the major findings is that most subjects with these disorders have multiple lifetime comorbid mood, anxiety, psychoactive substance abuse and/or impulse disorder diagnoses" (Kafka, 2000).

In spite of the benefits of medication, there are many sexually compulsive people who struggle with and resist medication. In describing her battle with manic depressive illness, Kay Jamison, Ph.D., a psychologist on the faculty of Johns Hopkins Medical School, characterized the war with medication that therapists also often see with clients who are very obsessed and compelled with online sexual behaviors as well as other out-of-control sexual behaviors: "It is hard for anyone with an illness, chronic or acute, to take medications absolutely as prescribed. Once the symptoms of an illness improve or go away, it becomes even more difficult. . . I missed my highs; and, once I felt normal again, it was very easy for me to deny that I had an illness that would come back" (1995).

Many medications quiet the eroticism which was so seductive in the first place. The attempt clients make to stop the behaviors or contain them, with or without medication, is a painful and difficult struggle and deserves much patience and support from everyone involved. It is humbling not only be in on the secrets shared but with the struggles to contain the behaviors.

Lastly, in the evaluation process it is not unusual to discover that people with sexual compulsivity attached to the Internet also have a history of early childhood sex abuse, exposure to sexually explicit material or events at an early age, other non-paraphilia related disorders or paraphilias, developmental issues, alcohol and substance abuse, promiscuity and/or many failed relationships. Sexual compulsivity attached to the Internet may develop after these mental health issues are well established or may be the result of an escalation of compulsive attachments to adult content sites on the Internet. It is also important to note that these clients often have learning disabilities which might benefit from evaluation and treatment as well (Kafka & Prentky, 1998).

Treatment Issues

"Treatment for compelling sexual behaviors is multi-modal, needs to be creative and flexible and is dependent upon many variables, not the least of which are the resources available in the community. Just as details are central to the assessment of these clients, so is the concept of management central to the treatment" (Golden, 2001). Containment may be the first order of business, but a full understanding of the concept of lifetime management rather than an instant "cure" must be established for everyone involved.

Treatment needs to be flexible and contain both psychodynamic and behavioral treatment strategies. There are also many concrete steps that therapists can use to counter and contain the effects of the Triple-A-Engine in the treatment phase:

1. Accessibility: In the first phase of treatment, putting the computer in a place at home or at work in rooms where the client is not alone may be a good initial containment technique. There are also many Internet Service Providers that can be used to prevent access to sexually explicit sites. While there may be limitations to the blocking programs, they at least can serve as containment techniques at the beginning of treatment" (Delmonico, 1997).

2. Affordability: In the treatment phase, another important task is to change the perception that online sexual activities have little or no cost to the individual. While in fact, adult content sites may be accessed free of charge, many do have a fee attached and, like telephone sex, many users may accumulate large credit card bills which they cannot afford in order to access such material. Furthermore, "it is useful to explore all of the ways that the online sexual behavior is exacting a toll, whether it be money, time, relationships or self-esteem" (Cooper, Putnam, Planchon, & Boies, 1999).

3. Anonymity: Finally, the secret is out and denial has been challenged. Treatment should include and support self-monitoring with behavioral techniques as well as provide the traditional psychotherapeutic process which develops self awareness and growth. Couples work should begin to help with issues that have polarized the couple as well as with the struggle of controlling the behaviors. It is essential to place the responsibility for self-monitoring firmly within the realm of the sexually compelled person and to help the partner or spouse to step back from taking responsibility for the problem. This work should also help both people in the dyad to understand that this is a lifetime management issue. The therapeutic goal for the dyad is to develop coping skills for healthy management of the issue within their system.

4. Finally, therapy groups can be an essential component of a successful treatment program. Many communities do not have existing therapy groups targeting this population and in more rural communities 12 step groups may not be available or practical. When groups do exist, it is important to assess their effectiveness and the "degree of fit" for individual goals. Some self-led groups may be misused, subtly enabling boundary violations or cruising by participants. Online sites and chat groups for prevention may also be helpful, particularly as a first step in challenging denial, exploring treatment options and resources and getting encouragement and support from others with similar issues. At the same time, it remains very important to help each person evaluate the usefulness of these web sites and how they function in the life of recovery.

Conclusion

In sum, the computer has become an ubiquitous part of modern life. It has changed how we think about communication, how we lead our everyday lives, and how we do business. Therefore, one might say we are all potentially at risk for being seduced into the web it weaves even if we only play solitaire, write e-mails or shop online. Even when it is

used for “strictly business,” the Internet has the ability to capture our addictive tendencies. Workaholics can be see at beach resorts and cafes typing away, eager to be with their anonymous and potentially addictive friend. Those with a propensity for obsessive and compelling behaviors connected to the Internet feel its powerful pull. Assessing and treating sexually compulsive clients is a “new age” problem and we are only beginning to come to terms with it. More research, treatment strategies and medications are needed which can bring more hope to those caught up in the struggle to put aside these preoccupations with online sexual activities.

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