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Alternative Sexual Practices

Of all the sexual difficulties mainstream therapists may face in their clients, perhaps none is as puzzling as alternative sexual practices, or paraphilias. A *paraphilia* is generally defined as sexual arousal to objects, events, or people outside what is considered the norm. The arousal can be created through fantasy or enacted in reality, and the accompanying release of tension through masturbation or sexual activity is highly rewarding, so that the person continues the behavior despite possible legal or other consequences. Although the exact mechanism is unknown, the rewarding nature of a paraphilia sometimes contributes to a person's sexual behavior becoming out of control.

In the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), a distinction is made between a *paraphilia* and a paraphilic disorder. A paraphilia in and of itself may not be automatically diagnosed as a psychiatric disorder. When a paraphilia causes distress or impairment to the individual, then it becomes a paraphilic disorder. To further break things down, a paraphilic disorder may or may not be illegal. A man who eroticizes feet, the common paraphilia, doesn't have a problem if his partner enjoys his fantastic foot massages. But this interest in feet or footwear might become a paraphilic disorder if the practitioner steals women's shoes, or even touches a woman's shoes in a sexual manner while she is wearing them.

Many paraphilic behaviors have gone mainstream and have been somewhat de-stigmatized. Call it the *50 Shades of Grey* (James, 2012) phenomenon, or attribute it to other media such as in-home "adult entertainment"; regardless, more people are experimenting with sexual behavior. For this reason, some clinicians have advocated that the diagnosis of paraphilia dropped from the book altogether (Moser & Kleinplatz, 2006). Also, for most people who practice some form of sexual expression outside what is considered the norm, the terms *alternative* or *kinky* sex are generally preferred; alternative sex is often referred to as *alt sex*. It is also important to note that some people who practice behaviors considered

outside the norm, or *vanilla sex*, resent these labels and would prefer others to not use them at all.

In their recent article, Pillai-Friedman, Pollitt, and Castaldo (2015) recommended that all psychotherapists become "kink-aware professionals" by receiving adequate education, training, and supervision. Per the PLISSIT (Permission, Limited Information, Specific Suggestions, and Intensive Therapy) model, they also should be able to provide information and suggestions to most kinky clients, with complex cases referred to thoroughly trained sex therapists for intensive therapy. Becoming kink-aware may be easier said than done, since "vanilla" (the kinky term for normative sexual practices) therapists and lay people alike associate paraphilias not with frolic and fun, but with sex offending, especially pedophilia, or the exploitation of children in fantasy and activity for sexual gratification. Other serious paraphilias for which people may be legally prosecuted if they are enacted upon another without consent include:

- *Frotteurism*: rubbing of one's genitals against another nonconsenting person
- *Voyeurism*: looking at nonconsenting people nude or involved in sexual activity
- *Exhibitionism*: displaying one's genitals to a nonconsenting person
- *Bestiality*: engaging in sexual fantasy or acts with an animal, with the latter being problematic because people believe in general that an animal is unable to give consent
- *Sadism*: deriving sexual pleasure from causing pain to nonconsenting others.

Most therapists know the harm pedophiles or other sex offenders create in trauma survivors, and offenders are generally treated as pariahs in our culture as a whole. It wouldn't be an exaggeration to state that one reason therapists decline to treat sexual problems is that they do not wish to treat sex offenders, for whom they may have limited compassion. While an argument can be made that nearly all (or all, depending on one's view) clients are deserving of compassion, there are critical considerations in working with offending clients that make a referral to a specialist in order. Psychotherapists trained to work with sex offenders are familiar with the legal system, reporting laws, and appropriate interventions, such as aversion therapy (pairing sexual stimulation with noxious stimulus), covert sensitization (pairing sexual stimulus with negative imagery), or psychotropic and antiandrogen drug therapy used to control sexual urges. Additionally, in some states such as California, anyone who has offended and is on parole is assigned a therapist by his or her parole officer.

Because of the association of illegal, exploitive sexual behaviors with legal, consensual sexual behaviors, therapists sometimes are fearful or even disgusted by any type of paraphilia. Nichols (2006, in Pillai-Friedman et al., 2015) stated that such feelings suggest that the therapist has unexplored parts of his or her own sexuality. In other words, most therapists, if they took time to reflect, would discover or have to admit that their own sexual fantasies and/or expression are not as romantic and pure as they might want everyone to believe; we all have what Carl Jung called a "shadow side" when it comes to sex. Consider common nonoffending kinky sex practices such as having sex blindfolded, suggesting submission and erotic power play. Other types of nonoffending alt sex include:

- *Fetishism*: Sexual gratification from an object or part of the body. Common fetish objects are high-heeled shoes, unique undergarments (e.g., a garter belt), or fabrics like leather or fur; coveted body parts include feet, legs, breasts, and so forth, often of a particular size or shape. People will sometimes go to great lengths to acquire objects or find a person with their favored attributes.
- *Sadism*: Sexual gratification from causing physical pain to or "power play" with a *consenting* adult. The dominant partner ("dom") may administer mild pain, such as biting, scratching, or spanking, or more extreme forms such as semistrangulation (asphyxiation, also called "breath play"). When a couple is engaged in consensual *sadomasochism*, they generally create a "scene" or script they will follow to ensure activity stays within certain boundaries, as well as a "safe word" that the submissive partner can use if that person feels overwhelmed or scared. There can be legal ramifications if a scene goes awry. For example, in some states a person cannot be considered as giving consent to a behavior that is illegal such as assault.
- *Masochism*: Sexual gratification from being physically hurt or engaged in "power play" in a *consensual* relationship. The masochist (submissive partner, or "sub") may engage in mild activity, such as spanking or light bondage, or may acquiesce or even request whipping, being tied in chains, or being physically overpowered. If the behavior is consensual and practiced with full knowledge that one is taking a risk of harm, then it is less likely to be indicative of pathology. See earlier regarding legal protection in some states.
- *Transvestism*: Deriving sexual and/or emotional pleasure from dressing in the clothing of the opposite sex; also called *cross-dressing*. Unlike a female impersonator or "drag queen" that dresses for theatrical performance, the male cross-dresser needs to engage in transvestism for sexual and emotional release.
- *Paraphilia NOS*: There are many very unusual paraphilias that cannot be found listed in the *DSM-5*, such as *coprophilia* and *urophilia*, or sexual gratification from feces and urine, respectively (also known as "scat," for "scatological"), *klismaphilia*, or gratification from the use of enemas, and *apotmenophilia*, which is sexual attraction to bodily amputations.

In terms of developing a tolerant and nonjudgmental stance toward nonoffending alt sex practices, consider what harm there is if a man masturbates to pictures of women's feet in stiletto heels—or cross-dresses in women's shoes or other garments. If a couple dresses in leather and studs, then visits a sex dungeon to meet friends for consensual sessions of sadomasochistic bondage and domination (BDSM), should they be considered deviants if they enjoy their activity? ("No different a social activity than bowling!" one such individual quipped in my office.) When a woman imagines having sex with a favorite stuffed animal ("plushophilia"), is she a pervert? Are any or all of these individuals mentally ill? Are they "sex addicts"? Are they just plain folk who are less inhibited than you are? Or as a button said on the lapel of the infamous Eli Coleman (professor and director of the Program of Human Sexuality at the University of Minnesota and former president of almost every sexological organization), "It's only kinky the first time you try it."

ALT SEX PRACTICES IN THERAPY

Although people who practice alt sex usually experience their behavior as ego syntonic and report being content with their sexual self-expression, they may enter therapy for the following reasons:

- Their behavior is so compelling that they cannot function sexually without it, for example, they develop erectile dysfunction (ED) or anorgasmia.
- They have had difficulty finding a tolerant partner.
- Their partner has discovered their behavior and feels disgusted or threatened.
- Their partner has participated in the behavior, but has tired of it.
- They have another psychiatric disorder, such as depression; these individuals will often seek out a sex therapist to avoid judgment.
- They fear becoming compelled to act out fantasies for which they may be arrested.

Those individuals who are self-motivated for therapy have a more positive prognosis than those who are brought in by a partner or who have been faced with arrest. Even so, alt sex behaviors can be deeply ingrained and difficult to treat.

WHO PRACTICES ALT SEX—AND WHY?

Due to fear of being misunderstood, shame, and stigma, secrecy marks alternative sex; no one is certain how many people are involved. A look at the alt sex site *fetlife.com* ("Facebook for kinksters like you and me") reveals membership of 1.3 million people; 2 million discussions; and 41,000 groups. A perfunctory search of *Google* gave the following numbers of hits:

- Bondage: 188 million[1]
- Dominatrix: 28.6 million
- Latex fetishism: 20 million
- Shoe fetish: 2 million
- "Cross-dressing guide": 2 million
- Urophilia: 1.9 million
- Plushophilia (attraction to stuffed toys): 49K
- Object sexuality (attraction to a building, a car, etc.): 57K
- Autoerotic asphyxiation (choking): 221K

Characteristics and personalities of those who practice alt sex vary widely, with the exception of gender, as it is mainly a male phenomenon. There are, however, some females who practice sexual sadism or masochism.

[1]At the time of this writing, E. L. James's books (*Fifty Shades of Grey, Fifty Shades Darker,* and *Fifty Shades Freed*) were listed as numbers one, two, and three on the *New York Times Bestseller*s list of print, e-book, and paperback books, which may explain inflated numbers for the term *bondage*.

STEP INTO MY OFFICE . . .

Born in a foreign country, Margaret was indebted to her American husband for teaching her English. However, he often requested that she wear a latex cat suit during sex because he could not tolerate the feeling of any imperfection on her skin. Seeing no harm, she initially went along with it, but now he was demanding that she wear it every time they had sex. Margaret came to feel he was making love to the suit and not to her. When I met with her husband Mort, it appeared that he had Asperger's syndrome (AS); he not only became aroused by the latex cat suit, but like some people with AS he disliked the tactile feel of human skin. Unable to relate to how wearing the cat suit affected Margaret, Mort refused to give up the cat suit. Ultimately Margaret ended the marriage.

No one is certain why some people develop interest in or practice alternative sexualities. There may be a biological foundation; those who practice sadism, for example, show greater activity in the amygdala and anterior insula when viewing pain pictures (Harenski, Thornton, Harenski, Decety, & Kiehl, 2012), and there is research, though scant, suggesting that male sadists and others who practice alt sex may have higher levels of testosterone (Jordan, Fromberger, Stolpmann, & Müller, 2011), buoying the practice of giving antiandrogens (testosterone-suppressing drugs) to sex offenders.

Does early development play a role? Many alt sex practitioners, particularly cross-dressers, report having kinky experiences as young as age 8 or 9. In the case of cross-dressers, psychoanalysts point to a person's wish to experience sexual pleasure without fear of castration. Attachment theorists disregard possible Oedipal urges, pointing instead to a person's inability to attain and maintain appropriate healthy relationships due to early trauma. Sexual gratification is sought with objects rather than humans; through pseudo-relationships, as with exhibitionism or voyeurism, rather than through real connection; or based on power differentials, as with sadomasochism, rather than mutual exploration (Wiederman, 2003). Or perhaps classical conditioning has occurred, with a person experiencing arousal paired with an object or experience, then strengthening the association with masturbation and fantasy or actual experiences.

Personality characteristics may also play a role (Seligman & Hardenburg, 2000), including low self-esteem, little empathy, poor insight, few social skills, and difficulty with impulse control. When confronted by a partner—or a therapist—they may alternate between self-deprecation and feelings of entitlement. Perhaps understandably, people who practice alt sex may also have mood disorders, anxiety disorders, or substance problems. (It must be remembered, however, that if such behaviors were truly destigmatized, such problems might be minimal, or unrelated to the sexual behavior.) In therapy, they are often guarded, fearing that they will be judged or having too much shame to admit their level of need or involvement with the alt sex behavior. They have difficulty trusting the therapist, making treatment challenging at least and impossible at times.

Even less is understood about the partner of the person who practices alt sex. In clinical practice, partners often feel threatened by unusual sexual behavior. I have observed very different responses in wives of cross-dressers, for example:

- A minister reported that not only was his wife divorcing him, but she had threatened to report his behavior to the congregation if he did not agree to give up his share of the assets.
- One woman tolerated her partner's cross-dressing, as long as he kept all evidence hidden and only did it when she was away on business.
- Another woman also did not participate with her husband when he cross-dressed, but she would buy him clothing and paint his nails for him.

Female partners of cross-dressers may report concern that their partner is gay, that they will not be able to arouse their partner, or that they themselves will be so turned off by their partner's behavior that they, themselves, will not be aroused. They also fear that if they tolerate a certain level of behavior that their partner will push the boundary. Thus, some partners will choose to terminate the relationship rather than live with the ambivalence created by staying.

STEP INTO MY OFFICE . . .

Leon and Amy both appeared shell shocked. Amy had discovered that her husband was involved in several affairs with women who were "subs" to Leon, their dom. Shortly after the discovery, Leon revealed to Amy that he was a survivor of a long history of incest. By way of explanation for what triggered his current behavior, Leon reported that when his business failed, he tried without success to get the reassurance he needed from Amy, who was distracted with taking care of their family. Under duress, he began having sadomasochistic dreams and fantasies that he eventually acted out.

Leon stated in therapy that after carrying out his consensual alt sex practices, he could not see himself being entirely happy in his somewhat "vanilla" or traditional marriage. Amy admitted that she had sometimes consensually engaged in mild scenes with Leon, but now that she learned that he enacted these behaviors with other women, she wasn't enthused about satisfying Leon's needs.

Leon declined psychotherapy to address issues related to sexual trauma and expressed that he did not wish to change his core sexual identity. Since Amy was open to S&M play, therapy focused on forgiveness for the affairs and engendering increased trust in the couple's relationship, as well as helping the couple negotiate how much consensual and scripted sadomasochistic activity they would engage in going forward. Note that in as much as some therapists may have wished for Amy to advocate for herself, her acquiescence to Leon reflected a deep-seated dynamic that would be futile to change unless both parties were agreeable.

ASSESSMENT AND TREATMENT OF ALT SEX PRACTICES

Before conducting any assessment, the therapist needs to adapt a nonshaming, compassionate stance toward the alt sex practitioner or practitioners. It can be helpful to remember that the alt sex practitioner has perhaps already experienced enough embarrassment, perhaps through being discovered.

Assessing alt sex practices as a problem for treatment often presents a few dilemmas. Is the person coming in for treatment because he or she wants treatment, or is he or she a partner who is expecting a change? When the behavior is ego syntonic, there is little motivation and treatment may be futile. However, in many cases the person who practices alt sex wants the benefits of a committed relationship (including whatever normalcy and stability it provides) and may be willing to flex in order to retain it. Conversely, it is often the "vanilla" partner who takes a hard stance that the alt sex partner must give up his or her fetish or cross-dressing altogether.

In assessing the alt sex practice, consider the following questions:

1. When did the behavior begin? Is it a long-standing behavior, or one that was more recently acquired, perhaps as a result of viewing certain pornographic material on the Internet?
2. How does the alt sex partner explain the behavior?
3. Is the person able to achieve sexual gratification in more normative ways with his or her partner?
4. Is the partner willing to participate in the alt sex practice in some way?
5. If the alt sex practice does not stop, will there be dire consequences to the relationship?
6. What is it about the alt sex practice that is threatening or disturbing to the non–alt sex partner?
7. Has the alt sex partner tried to stop the behavior? What happened?
8. What positive emotional and sexual feelings does the alt sex practitioner get from the behavior? What negative feelings?
9. What was the partner's response to the alt sex practice?
10. What does the alt sex practitioner consider a realistic goal? What about the partner?
11. Is the person at risk for offending? (If high risk, such as fantasizing about sex with children, consider referral to a specialist in treating sex offenders.)

Additional assessment of mental status and the sex and relationship history of both partners is also in order to rule out problems such as bipolar disorder, a history of trauma, and/or substance abuse. The therapist cannot assume, however, that there must be a comorbid diagnosis, nor should he or she overpathologize the behavior.

Depending upon the chronicity, severity, and treatment goals, a referral to a psychiatrist may be appropriate to improve mood and manage anxiety and/or sexual urges of a compulsive nature. If the alt sex practice is more difficult to control, then keeping a log of urges and accompanying feelings can help the client understand and break an unwanted pattern, most likely by helping the client cope with dysphoric mood or anxiety. Substance abuse problems may also need to be addressed, but not without providing supportive treatment and coping skills. I have also made referrals to a urologist when it appears that the alt sex practice started

late in life, as this sometimes indicates that a male is attempting to compensate for poor erectile function by involving himself in highly stimulating alt sex rather than through requesting more stimulation from his partner.

Other treatment approaches vary. Often there is a cognitive behavioral component to address irrational ideas about sex such as, "My partner 'must' wear latex if I am going to be aroused," or "Vanilla sex is 'always' boring." Open communication is also essential if the partnership is to survive; various questions can be posed for exploration, such as how each partner defines "normal" sex or his or her theories of how people develop sexually.

Information can be broadly supplied, such as explaining what is known about alt sex practices, the possible relationship to early trauma, or how to achieve arousal with one's partner without alt sex. Suggestions for change include sensate focus techniques as well as finding new practices that both partners can enjoy, for example, introducing toys, body paints, objects like feathers or a fur mitt, and light bondage items such as Velcro® handcuffs or a soft blindfold. The couple then may negotiate a certain percentage of traditional sexual experiences versus alt sex experiences.

This chapter has focused on tolerance and acceptance of nonoffending alt sex practices when possible, but not every client has the same level of self-compassion. People are often extremely embarrassed and wish for removal of the behavior. In such cases, intensive therapy is recommended, with treatment goals of improving self-esteem, eliminating shame, and correcting irrational ideas about sex, as well as exploration of early childhood sexual memories and experiences that may have contributed to nonnormative sexual development. The client needs to be fully informed that it is unknown if therapy will lead to the desired result. Such therapy is usually long and arduous, and it is the rare client who will be able to let go of behavior that has been so rewarding.

TAKE-AWAY POINTS

1. A paraphilia is said to occur when a person is sexually aroused by an object, event, or body part rather than normative sexual behaviors. The practice of paraphilias is referred to as *alternative sex, alt sex*, or *kinky sex.* Normative sexual behaviors are sometimes called *vanilla*.
2. The *DSM-5* makes a distinction between a paraphilia and a paraphilic disorder. The latter is diagnosed only when the person's behavior causes him or her distress. A paraphilic disorder may be criminal or noncriminal in nature.
3. Due to mass media exposure, alternative sex is now more mainstream and acceptable. Thus, therapists need to be "kink-aware." Even if they will ultimately make a referral to a dedicated sex therapist, nonoffending people who have unique sexual practices must be treated with compassion. Those who do offend may find limited compassion, and they need to be treated by those trained to treat sex offenders.
4. It is unknown why some people—mainly men—develop a paraphilia, and it is considered resistant to treatment. Especially if the paraphilia is nonoffending, the general consensus is that the person learns to accept his or her behavior in addition to becoming more flexible if he or she wants to maintain an intimate relationship.
5. Partner responses range from disgust to acceptance. Some partners are tolerant and will agree to some level of participation in a particular behavior.
6. A *kink-aware therapist* is one who does not assume that a paraphilia is problematic; that many forms of sexual expression are acceptable if they do no harm; and that the therapist needs to acknowledge that he or she, too, may have fantasies or have acted on behaviors that might be considered outside the norm, even if they are mild, in order to engender compassion for the client who is kinky.

ACTIVITIES

1. If you, yourself, do not have any alternative sex practices, reflect on potential countertransference to those who do. What feelings do you have about working with this population? Are you capable of providing compassionate care? Discuss with a trusted colleague or supervisor who is versed in working with this population.
2. Reflect on what value there might be in facilitating someone's interest in alt sex practices. Might you make recommendations on books (see *Resources*), DVDs, or locales where an isolated person might be able to fulfill sexual wants?

RESOURCES

Blue, V. (2011). *Sweet confessions: Erotic fantasies for couples*. San Francisco, CA: Cleis Press.
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Out-of-Control Sexual Behavior

Internet pornography use has grown exponentially since so-called adult sites were first launched. Searches for Internet pornography are ranked number one, and visits to pornography sites are said to account for half of all Internet traffic. A joke recently circulated that a researcher wanted to conduct a study on men who had never viewed pornography, but he could not find a single subject, reflecting a belief that *all* men look at pornography. (Women look, too, but a researcher would have no problem finding female subjects for such a study.) In my practice, only men who grew up in conservative countries without early Internet access seem to have circumvented looking at explicit sexual material.

What if someone watches pornography every single day—are they addicted? When someone enjoys anonymous sex in an online chat room—is that a sign that he or she is seriously disturbed? What if the person using the chat room lives in an isolated rural area, or is in some way disabled? Does that change the meaning of his or her behavior? What if the person is currently married but his or her spouse has no interest in sex; should the individual never experience sexual pleasure again? Or if this is deemed acceptable, when would the individual's behavior become a problem? How does anyone know? Who decides the nature of out of control sexual behavior (OCSB)?

Therapists are understandably confused, because experts are not in agreement regarding the answers to these questions. On one end of the spectrum are therapists trained to treat sexual dysfunction, who may argue that watching adult entertainment is a healthy outlet when a partner is unavailable. On the other end are therapists trained in treating sex addiction, who believe that pornography has no place in anyone's life; only partnered sex between two heterosexual individuals is the norm. Such disparate views are fascinating to ponder, but leave the therapist wondering what to do when an individual gets referred for treatment because he or she was found masturbating to pornography at work, or when a couple comes into the office on the verge of divorce because the husband was found "sexting" a neighbor. Like alcoholism, is this behavior a disease, or is it reflective of something deeper?

HISTORICAL VIEW

Historically, it has not gone unnoticed that some people seem to have a big appetite for sex, a fact considered gross and even sinful by others not so inclined. This is reflected in pejorative terms used to describe heightened interest, including *Don Juanism* and *satyriasis* in men, and *nymphomania* in women. The 18th century Swiss physician Samuel-Auguste Tissot (1767/2010) described *onanism* (masturbation; derived from the name of Onan, who in the Bible infamously "spilled his seed") as a morally degenerative activity that could cause diseases such as acne. Benjamin Rush, an early American physician, documented excessive sexual behavior in 1812, and Krafft-Ebing (1865/1965) described *hyperesthesia sexual*, or an abnormally large sexual appetite, in the early 1900s. Various religious organizations have condemned masturbation, turning what can be a healthy, solitary sexual outlet into an act against God, one to be stopped with willpower, or prayer.

In the latter part of the 20th century, the book *Out of the Shadows: Understanding Sexual Addiction* by author and educator Patrick Carnes (2001) described *sex addicts* as primarily men who compulsively engage in sexual activity despite negative consequences. Perhaps significantly, the book was originally published in 1983, the same year that scientists identified the AIDS virus, when curbing sexual activity became not only a concern of public health, but life and death. In any case, Carnes' book clearly struck a nerve as an entire industry devoted to sex addiction treatment has exploded. A perfunctory Google search using the term "sex addiction programs" returned 1.47 million results. Such programs offer rehabilitation similar to that for substance disorders, requiring that clients refrain from masturbation, sexual fantasies, and pornography lest the person relapse. There are also spiritually based 12-step meetings to reinforce the disease model.

This industry has grown despite the fact that the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) does not include a diagnosis for sex addiction. In anticipation of the publication of the last *DSM*, the Workgroup on Sexual and Gender Identity Disorders had proposed a diagnosis of hypersexual disorder (HD; also known as *hyperactive sexual desire*), defined as spending excessive time thinking about, planning, or engaging in sexual behavior; using sex as a coping mechanism in response to negative mood or irritability; and engaging in repetitively sexual acts and/or fantasies in response to stressful life events (Kafka, 2010). The behavior continues despite significant risk of harm to oneself or others.

HD was rejected, however, due to lack of research (Kafka, 2014)—and researchers have responded to the call. For example, brain studies using fMRI and PET suggest that the *anticipation* of using pornography sets in motion a cascade of reward chemicals, especially dopamine, much as occurs in gamblers, compulsive shoppers, heavy exercisers, and video game users. Notably, the amygdala—which is associated with seeking sexual stimuli—seems to have greater involvement in men than in women in regard to the processing of sexual signals (Karila et al., 2014). Karim and Chaudhri (2012) report that HD potentially interferes with the brain's prefrontal cortex and the person's ability to either evaluate the consequences of or to inhibit compulsive sexual behavior.

In terms of prevalence of HD, Karila et al. (2014) reported in a review article that about 3% to 6% of adults appear to engage in "sexually addictive" behavior, including looking at Internet pornography, visiting strip clubs, having sexual activity with other consenting adults, and so forth. Engagement in such behaviors

may negatively impact a person's life by creating relationship conflict, reduced productivity at work, or decreased social interactions. Behaviors may also result in arrest if the person ventures into engaging with sex workers or becomes predatory on the Internet.

There are, however, researchers who completely disagree with the idea that sexual behavior of any kind can be "addictive" (Ley, Prause, & Finn, 2014). Addiction, they argue, cannot be applied to a behavior, and it has become too broad a term, as in "I'm 'addicted' to popping bubble wrap." Even in regard to substance disorders, addiction is not always well understood, for example, cannabis is a drug that does not always seem to be addictive.

Ley et al. (2014) also point to positive aspects of using what they refer to as visual sexual stimulation (VSS, an alternative to *porn* and what they deem to be other derogatory terms for adult entertainment), including improved attitude toward sexuality, better quality of life, and experiencing a wider variety of sexual behaviors. Because there is no live interaction, the risk of contracting an STI is nil. VSS may provide a legal outlet for sexual gratification that is associated with illegal activities, for example, there is a large market for so-called "rape porn," in which actors perform role-play that some find erotic. Although the idea of this type of material may be distasteful for some, it also seems that VSS use has been associated with a decrease in sex offending.

Whatever researchers hypothesize, the fact remains that there is no *DSM* diagnosis. In addition, unlike other sexual disorders, treatment of sex addiction or HD is not dependent on the restoration of sexual health. This lack of attention to sexual health has concerned therapists trained in sex therapy, as opposed to Carnes' addiction model, many of whom have adopted the term "OCSB" to describe the complaints of clients that seek treatment. In a book on the topic of OCSB, authors and sex therapists Braun-Harvey and Vigorito (2015) define OCSB as "a *sexual health problem* in which an individual's consensual sexual urges, thoughts, or behaviors feel out of control" (emphasis added). The feeling of being out of control may be associated with one's sexual fantasies or behaviors being out of sync with his or her core values and beliefs. Braun-Harvey and Vigorito have pared down the commonalities of several sexual health models to six principles of sexual health:

1. *Consent*: Every individual involved is voluntarily willing to participate in sex.
2. *Nonexploitation*: Not using power or control to manipulate or coerce someone into having sex.
3. *Protection from HIV/STIs and unintended pregnancy*: Practicing safer sex, including regular testing for STIs; accurate contraceptive information and use.
4. *Honesty*: Being open with one's self and one's sexual partners.
5. *Shared values*: Understanding the meaning of sexual values and acts for one's self and one's partner.
6. *Mutual pleasure*: The erotic needs of one's self and one's partner are communicated and tended to.

Such principles create a "launching pad" for exploration of a person's sexual history and how it does or does not comport with his or her core values in a nonshaming way.

Some researchers also believe that OCSB can be understood as a symptom of an avoidant attachment style. Zitzman and Butler (2005) state that certain sexual behaviors create a "[p]rofound disconnection of the sexual experience from relationship context and meaning." In younger clients, OCSB may be an escape from potentially painful social and romantic interactions. In older clients, OCSB may reflect the user's inability to get sexual needs met as sex with a familiar partner may not be as stimulating as pornography; the OCSB individual, and possibly the partner, may not realize that emotional connection, secure attachment, and communication about changing sexual needs could potentially compensate for lower levels of arousal.

Family therapy researchers have viewed OCSB as a problem of boundary violations, inappropriate sexual coalitions, secrecy, and poor communication (Ford, Durtschi, & Franklin, 2012)—all of which interfere with sexual health. For example, the individual with OCSB may engage in the behavior because of relationship dissatisfaction, creating a coalition against the partner. Pornography use is likened to a relationship betrayal that is similar to infidelity if the couple has an agreement based on shared values that it is not to be viewed. The systemic treatment approach might be to have the couple join against the problematic material and rebuild their relationship through increased communication.

In conclusion, what can truthfully be said about OCSB today is that it is not diagnosable in the traditional sense. OCSB is perhaps best viewed as a socially and relationally constructed phenomenon, one that may violate some people's moral values, and which clients complain about and want curtailed or stopped. But how does one treat a problem that seems to be a matter of perception? As with other issues that come to light in the therapy room, the therapist needs to take a nonjudgmental stance, putting aside preconceptions about what OCSB is or isn't and to listen to the client's or couple's experience.

ASSESSMENT OF OCSB

Since what most people know about OCSB comes from media—some of it sensational—they will contact the therapist seeking help for sex addiction. Generally, it is best to accept that person's self-diagnosis and proceed with the intake. As always, conduct a general assessment first to rule out substance and mood disorders, ascertain any relationship problems, and determine level of function. Then, an ecosystemic framework can clarify what the client's complaint of OCSB means and how it might be resolved. For whom is this behavior problematic? What function is the behavior serving for the individual and the system? How will solving the problem make things different? What is the goal of treatment? Is it to abstain altogether, to come to some agreement about when pornography is or isn't to be viewed, or is the couple going to find a way to make pornography part of their sex life together? How does each couple member define sexual health, and what do they see as the obstacles to attaining it?

Looking at the microsystem, for some individuals, OCSB begins at a young age, even predating the Internet. One gentleman I worked with discovered, at age 8, two large drums of pornographic magazines and videos in an abandoned house. Somehow the client managed to keep his huge stash of material secreted

away from his parents. Another client reported that he was an "early adopter" of the Internet in his preteens. His parents were naive and never realized that he was spending hours in his room masturbating to all kinds of sexual materials. For these men, using pornography became a secretive way to avoid relationship conflict and deal with painful emotions. Although no one knows how early exposure to pornography impacts sexual and social development, this is an issue to be explored with the client.

OCSB has been associated with major depression, the manic phase of bipolar disorder, anxiety, and attention deficit hyperactivity disorder (ADHD). In clinical practice, men who complain of OCSB often have low self-esteem and tend to isolate themselves or become avoidant when they experience stress. During times of social withdrawal, they turn to pornography to relieve duress. Single men who compulsively use pornography may lack social skills; often they are lonely or bored. Men who are self-employed or who travel as part of their work seem to be, in my experience, more at risk for turning to the Internet for diversion and comfort.

Another variable to consider is whether the OCSB includes involvement in paraphilic activity, as suggested by an examination of 30 case studies by Levine (2010). Partners are sometimes shocked to learn that their mate is viewing material about, or participating in behavior involving, bondage or other alternative sexual behaviors. After the discovery, some partners may see this as positive, because their partner is satisfying a sexual need without requiring their participation. Others find it gross or threatening enough that the viability of the relationship is threatened. In terms of sexual health, however, it may reflect that many men have difficulty communicating their sexual needs to their partners, perhaps for fear of being judged or having their wish rejected. Perhaps keeping sexual secrets and being sexually dishonest is more at the heart of OCSB than lack of willpower, increased dopamine, or addiction to masturbation.

STEP INTO MY OFFICE . . .

William, a young bisexual man dressed in a t-shirt and wearing flip flops, squirmed and laughed when he admitted to me he got sexually aroused by looking at men dressed in business suits and tuxedos. He had been able to hide both his interest and his sexual orientation until one day, feeling a little bored and sad, he decided to look at images on the Internet. Not only did he find images designed specifically to satisfy his interest, but also forums and chat rooms of other men who enjoyed dressing up. He made a decision to disclose his wish to his wife Kate that he wanted to make love to her while he was wearing a tuxedo. Although he protested that he had no interest in having sex with men, Kate still felt threatened and disgusted. Treatment consisted of finding ways to talk about William's bisexuality, his fidelity to his wife, and his seemingly odd fetish. Once Kate felt she could trust William not to stray into having sex with anyone else, she was able to concede that William could look at images as long as they maintained a healthy sex life together.

OCSB AND THE PARTNER RELATIONSHIP

At the level of the mesosystem, examine how the partner reacted when he or she discovered evidence of OCSB. In an addiction model (Carnes, 2001), the partner is described as a "codependent" that is afraid to set a firm boundary for fear of being abandoned. A codependent compulsively looks for evidence that his or her partner is "sober," or refraining from masturbation, much as the partner of an alcoholic becomes overly concerned about drinking. When viewed through a sexual health lens, however, the couple dynamic appears different. When someone uses pornography as a substitute for partnered sex, it can be heartbreaking to learn that the partner *does* have a drive, but for reasons that are not well understood, it is not directed toward someone who is willing and waiting to be intimate. Sometimes the partner has a restricted or black and white view of sex that has made communication about sex difficult on both sides of the relationship.

Whether due to diminished intimacy within the relationship, or moral judgment by the partner, the partner's reaction is sometimes similar to the betrayal associated with infidelity. As with infidelity, the partner and/or couple may ask what has gone wrong in the relationship, seeking answers to stop the pain of relationship betrayal. The impact on a woman's self-esteem can be enormous; often statements such as the following are made:

"I can't compete with the perfect women he's looking at online!"
"Why did he need to go elsewhere for sexual satisfaction? Aren't I enough?"
"I am so disgusted by his behavior, I can't even look at him."
"It's just a straight out sin to do what he was doing!"

The partner with OCSB typically responds in one of two ways: either denying the extent of use or exhibiting a certain level of entitlement (e.g., asking, "What's the big deal?"). As the individual comes to terms with disappointing his or her partner, that person may experience remorse and guilt.

But what is the underlying nature of this betrayal? Partners sometimes vehemently disagree about viewing pornography—a function of the macrosystem. The consumer of pornography may view it as a diversion, like watching a sporting event, while the partner views it as the height of sin. The issue of pornography use may be the tip of an iceberg regarding differences on religion and morality, relationship roles and rules, and the amount of personal freedom within a relationship that each partner can tolerate. Many couples look to the therapist to advocate for one view or the other. As with any disagreement between partners, the remedy is not for the therapist to opine on pornography, but to guide an exploration of what does and does not work within the framework of their relationship.

If the goal of treatment is to attain or regain sexual health for oneself and one's relationship, then the couple needs to explore what this means. How does each partner understand his or her sexuality? Are they able to communicate their sexual wants or needs? Are all activities that do not include the partner forbidden, or are any acceptable as long as they are not conducted in secret? What happens if the couple disagrees on the role of solitary erotic activities? How will they come to terms with their differences regarding masturbation and fantasy life?

TREATMENT OF OCSB

Inpatient and intensive treatment for sex addiction is well known due to publicity whenever a celebrity involved in a sex scandal enters this type of center. While individuals who are substance dependent may need intensive treatment because of potentially fatal withdrawal symptoms, people with OCSB benefit from outpatient psychotherapy. In some cases of OCSB—when masturbation is so frequent that it has caused injury, for example—a medication evaluation is recommended. Antidepressants can not only help the person with OCSB cope with negative affect, but potentially the sexual side effect of decreasing libido may help the person gain control over his or her behavior while the person learns other means of coping with negative affect, escapism, and emotional isolation.

In individual therapy, Braun-Harvey and Vigorito's (2015) six principles of sexual health can be explored, as can themes related to emotional intimacy, attachment, vulnerability and dependence, and the need for control of one's sexual urges. In a case study presented by Marcus (personal communication, 2010), the client demonstrated a need for control even at the outset of therapy, making the development of a therapeutic relationship challenging to establish. Thus, developing rapport, remaining nonjudgmental, and normalizing that there may be setbacks can all contribute to the increased likelihood of a successful treatment outcome.

Although clearing the environment of pornography and any triggers, such as racy scenes on cable television, seems like an appropriate intervention, for people with OCSB it may be unnecessary and create additional feelings of shame. Just as there are alcoholics that can be at a bar or holiday party without getting triggered to drink, there are people that can refrain from watching pornography on the home or office computer.

What can be more effective is for individuals to become aware of and express negative affect that they experience when they feel an urge to engage in OCSB and to process it in therapy. Keeping a thoughts and feelings journal can yield valuable information in this regard. Together with the therapist, they can then develop a contract with themselves regarding what are and are not sexually healthy or triggering behaviors.

Since isolation can be a major part of OCSB, group therapy in which members have a shared goal of achieving and maintaining sexual health may be helpful (Braun-Harvey & Vigorito, 2015). It can also help to have the individual identify healthy activities that may get him or her out of the house, be more social, and develop a habit of self-care to improve affect regulation. Yoga seems to be a favorite because it helps to relieve physical tension and is calming to the mind. Simply taking a walk or calling a friend to meet socially can make a difference. Volunteering is another way to get out of one's own way and feel a sense of purpose.

When a partner's OCSB feels like infidelity, the partner with OCSB needs to demonstrate understanding of why his or her behavior has been hurtful to a partner (e.g., the person violated shared values or hasn't shown the partner sexual interest), and the partner needs to be permitted to ventilate anger, loss, or hurt, with the eventual goal of forgiving the partner with OCSB and establishing or reestablishing an intimate connection. Once the relationship is stable and the couple have recommitted to the relationship, attention can be turned to

issues of sexual health. Sexual dissatisfaction is estimated to affect about 25% of marriages (McCarthy & McCarthy, 2014) and is one reason that men report engaging in OCSB. Some dissatisfaction may be attributed to the partner's sexual dysfunction, such as low sexual desire or sexual aversion, but often it is a cocreated issue. For example, the partner with OCSB may have an inability to discuss his sexual wants and needs with his partner, over which he may have experienced shame, or feel uncomfortable about bringing his "dirty" behaviors into the "clean" bedroom with his "pure" partner. Or, he may not discuss his sexual needs because he wants to avoid conflict.

Couples need to learn how to negotiate their varying needs. Sexual activities may be overly constrained or lack variety. Even if the non-OCSB partner expresses disinterest in a particular activity such as performing oral sex, if he or she can understand the core need, most problems can be worked out. For example, does the OCSB partner want to be dominant, or passive? Does the desire for a particular act reflect that the person would like a partner to initiate more? Is there anything that the non-OCSB partner wants from the sexual relationship that he or she hasn't expressed? Does the partner want sex to feel more connected or meaningful, for example? What behaviors would reflect this, for example, longer foreplay?

WHAT CONSTITUTES HEALTHY SEXUALITY? TOPICS TO BE EXPLORED

- Must sexual activity always take place between two people?
- Is there a time or place for solo sex?
- Why is pornography acceptable or unacceptable?
- Are people who are married or in a committed relationship entitled to some private sexual behaviors?
- How open is each partner to satisfying each other's particular sexual needs?

TAKE-AWAY POINTS

1. The concept that some people have a strong sexual appetite is not new, nor is the moralistic view of solitary sex. Whether such sexual activities constitute a disorder has not been established.
2. A diagnosis of hypersexual desire was proposed for the *DSM-5,* but rejected because there was not enough research to support its inclusion. There is also no diagnosis for sex addiction in the *DSM*.
3. The concept of OCSB is nonshaming and it is addressed by examining and making repairs to an individual's and couple's sexual health.
4. While a partner's discovery of OCSB may look like infidelity, it can also be understood as a lack of communication regarding issues concerning individual sexual freedom, differences in moral outlook, and a need for discussion about one's need for emotional and physical intimacy.

ACTIVITIES

1. Reflect in your journal on your beliefs about looking at pornography. How might they support or be at odds with the experience of mainstream American adults? Are there any times when looking at pornography might be beneficial, or is it always a negative experience?
2. How might you handle the following common clinical situations:
   - A couple that practices a fundamental, conservative religion; the man looks at pornography once or twice a month and the woman wants him to refrain from looking at pornography altogether.
   - A single man who wonders if his constant viewing of pornography is of any consequence.
   - A woman who cannot get aroused for sex with her long-term partner unless she watches pornography while using a vibrator.
   - A teenage boy with Asperger's syndrome who looks at pornography because he is too socially awkward to relate to teenage girls.
   - A man who downloads child pornography "because it's better than getting caught fondling a child."

RESOURCE

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DEALING WITH OCSB

Problematic pornographic viewing behavior (OCSB) can interfere with your self-esteem, your sexual function, and relationships. OCSB can be thought of as a *process addiction*, that is, instead of being addicted to a substance, a person becomes addicted to a behavior. A process addiction is like a habit. Like all behaviors, some habits are healthy and some are unhealthy. Watching football can be healthy for relaxation, but unhealthy if it means not spending any time with a partner. Some people think all viewing of pornography is problematic; that will be something that you can decide with your partner and your therapist.

One way to overcome OCSB, or any process addiction, is to make a plan. Researchers think that when someone develops a process addiction, the part of the brain that protects that person from engaging in unwanted behavior doesn't work the way it should. If you have a plan, then you can compensate for that part of the brain and do a better job of stopping or avoiding OCSB. Examples of planning include the following:

- Keep a log of times when you feel like engaging in OCSB. This can make you aware of what triggers you to engage in this behavior so you can do something else instead.
- Make a list of things that will relieve whatever feeling you are trying to avoid or fix when you engage in OCSB. If you engage in OCSB when stressed, what else can relieve stress? If it happens when you are sad, what is making you sad, and what will help make you feel better? If you identify your feelings or needs, you can usually do something about them to make things better.
- Find enjoyable activities that you can plan in order to remind yourself that there are other ways to have fun besides OCSB.
- When you have an interest in OCSB, ask yourself honestly if you are avoiding dealing with an issue in your relationship. If so, be honest. Communicate your wants and needs openly with your partner. Let your partner reciprocate. In this way, you will build real intimacy and find your need for OCSB dissipates.