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Weston Edwards

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ARTICLES

Applying a Sexual Health Model to the Assessment and Treatment of Internet Sexual Compulsivity

WESTON EDWARDS
Sexual Health Institute, Minneapolis, Minnesota

This article describes the application of the Sexual Health Model (Robinson, Bockting, Rosser, Miner, & Coleman, 2002) to treatment for cybersex. A brief summary of the historical development of the model is followed by a deeper review of how the model is important in addressing the issues related to cybersex. Specific strategies are discussed regarding the components of the sexual health model as a pathway for interventions addressing problematic cybersex behaviors. Specific exercises and activities for each of these components may be found in the Edwards, Delmonico, and Griffin (2011) workbook, Cybersex Unplugged.

This article describes the application of the Sexual Health Model (Robinson et al., 2002) to treatment for cybersex. A brief summary of the historical development of the model is followed by a deeper review of how the model is important in addressing the issues related to cybersex. Specific strategies are discussed regarding the components of the sexual health model as a pathway for interventions addressing problematic cybersex behaviors. Specific exercises and activities for each of these components may be found in the Edwards, Delmonico, and Griffin (2011) workbook, *Cybersex Unplugged*.

The Sexual Health Model

Robinson et al. (2002) published their model in an attempt to apply a sexual health promotion model to HIV prevention. Their hypothesis was that a sexually literate person who was comfortable with sexuality would make healthier choices regarding HIV risk behaviors. The model was based

Address correspondence to Weston Edwards, Ph.D., Sexual Health Institute, 3232 Emerson Ave S, Minneapolis, MN 55408. E-mail: weston@westonmedwards.com

on three components: (a) characteristics of the sexual attitude reassessment (SAR) seminars reflecting the diverse topics of the AASECT standards; (b) a literature review related to culturally diverse sexual health approaches respectful of a community's culture; and (c) research on various population factors related to safer-sex decision making. The model was designed to be respectful of the unique target populations, employing a pluralistic definition of sexual health. The model has been applied to a range of populations including participants who attended SAR workshops over an 18-year period at a large university in the Midwest, men who have sex with men, African-American women and men, transgendered individuals, women who have sex with women and men, and Latino HIV prevention workers. A subsequent application of the model to treatment of sexual dysfunction has also occurred. (Robinson, Munns, Weber-Main, Lowe, & Raymond, 2011).

History of Applying the Sexual Health Model to Sexual Compulsivity and Cybersex

At a 2003 national conference sponsored by the National Council on Sex Addiction and Compulsivity (precursor to the current Society for the Advancement of Sexual Health), Edwards (2003) presented a workshop on applying the sexual health model to treatment of sexual compulsivity. The workshop developed into a published curriculum adapting the sexual health model to treat sexual compulsivity (Edwards, 2009a) and later adapted to cybersex (Edwards et al., 2011). Since 2008, the model and curriculum has been in use at a treatment program on the residential and intensive outpatient level (Edwards, 2009b) addressing the overlap of sex, drugs, and the Internet (Edwards, 2010).

Strengths and Goals of the Model

Various authors (Bancroft & Vukadinovic, 2004; Carnes, 1992; Coleman, 1991; Goodman, 2001; Kafka, 2010) have attempted a taxonomy to help the field of sexual compulsivity develop a theoretical approach. This taxonomy has yet to be adapted to cybersex behaviors. Using the sexual health model, the approach in this article sidesteps the debate that has beleaguered the field of sexual addiction and sexual compulsivity by focusing on a health-based approach rather than a problem-focused approach. Reflecting its design, the sexual health model can respond to cultural and gender differences that current approaches sometimes lack (Ferree, 2001). The model is able to focus on the meaning of any particular behavior within the context of the individual. The behavior is then a symptom versus the problem itself.

The overarching goal is that the client defines for himself or herself what is sexually healthy, both online and offline, in conversation/dialogue with

their primary support network. Similar to Robinson, it is hypothesized that informed clients will make healthy choices regarding cybersex behaviors. Consistent with motivational interviewing, it is believed clients will change their sexual behavior when they see change as in their best interest (Miller & Rollnick, 2002). The content of the model is designed to provide clients tools and knowledge to understand the foundations of sexual health. The content is tailored to the needs of the client consistent with the Stages of Change model (Prochaska, Prochaska, & Levesque, 2001) and developmental theory (i.e., Vgotsky's Zone of Proximal Development; Berk & Winsler, 1995).

COMPONENTS OF THE SEXUAL HEALTH MODEL

What follows is a brief discussion of the sexual health model as applied to the treatment of problematic cybersex behaviors. The components reflect the Robinson et al. (2002) model with slight adaptations.

Talking About Sex

This is a cornerstone of the Sexual Health Model that includes talking about one's own sexual values, preferences, attractions, history, and behaviors. The starting assumption is that if there is any topic from the subsequent components that a client isn't willing to talk about, it is a probable treatment topic requiring additional assessment and possible intervention. A review of why he or she isn't willing to talk about the topic needs to occur. Specific assignments in this component include completing a Sex History (not limited to but including a comprehensive cybersex history) and a Life Timeline (how do the sexual behavior and life factors relate to one another), and completing a detailed weekly Internet sexual behavior log. Through analyzing the history/timeline and Internet log, the client and therapist will be able to identify clinical topics he or she believes are most important to address in treatment. Respectful clinical collaboration builds on these initial topics.

Culture, Values & Stereotypes

Clients need to examine the impact their particular cultural heritage has on their sexual identities, attitudes, and behaviors. It is consistent with a client understanding his or her personal story as a factor of culture. Adapted from Hays (2008), the sexual health model was nuanced to help clients address their integrated cultural identities, particularly when they are in conflict with each other. Hays coined the ADDRESSING Model (referring to A-ge, D-isability born with, D-isability acquired, R-eligion, E-thnicity/Race, S-ocio-economic Status, S-exual Orientation, I-ndigenous Status, N-ationality,

G-ender) that affirms the cultural complexity within the individual. The client needs to resolve the internal conflict that occurs as a function of his or her cultural identity. For example, an African-American, gay male, Baptist who was recently diagnosed as HIV+ will need to integrate all aspects of his identity. He might use the Internet as a way to avoid this conflict, including compulsive cruising online to avoid real-time encounters. This is a process that may require rejecting aspects of one's history, confronting unrealistic cultural values, developing self-efficacy, or perhaps developing new methods to integrate the conflicting elements in new and undiscovered ways.

Strategies for developing cultural identity include the use of various theories of Cultural Identity Development (e.g., the Racial/Cultural Identity Development [R/CID] Model, White Racial Identity Development; Sue & Sue, 2008); sexual identity development (Shively & DeCecco, 1977); LGBT identity development (Bockting & Coleman, 2007; Cass, 1978; Coleman 1982; Rust, 2002; Troiden, 1988); and straight identity development (Diamon, 2000). As an example, Amico (1997) highlights that a client may be going through the stages of "adolescent" tasks of sexual identity development versus engaging in sexually compulsive behaviors.

Online sexual behavior needs to be interpreted through an appropriate cultural identity as well. In this case, some cybersex behaviors may actually represent appropriate identity development tasks overcoming identity stagnation (Cass, 1979). It is important to note that simply because a person engages in online same-sex behavior doesn't necessarily imply a same-sex identity (Kort, 2012). The clinician must hear the story behind the online sexual behavior to understand the cultural context. Assignments in this component include a client-centered cultural assessment, review of components of sexual identity, and when appropriate, examination of the LGBT identity development models.

Sexual Anatomy and Functioning

Clients need a basic understanding, knowledge, and acceptance of sexual anatomy, sexual response, and sexual functioning. First and foremost, this often requires basic education regarding the sexual response cycle for many clients. Too often, clients lack the basic understanding of how the body reacts sexually. Next this component reflects the belief that sexual health includes freedom from sexual dysfunction and other sexual problems. Appropriate referrals are needed to address sexual dysfunction concerns including painful sexual intercourse for men and women (e.g., dyspareunia, vaginismus, anodysparunia, anorgasmia, erectile or ejaculation problems, and low or inhibited sexual desire). Unique approaches need to be tailored to the individual examining both gender differences and etiology (Bean, 2002; Nusbaum, 2002; Nusbaum, Lenahan, & Sadovsky, 2005; Robinson et al.,

2011). Given the impact of many psychotropic medications (i.e., SSRI), sexual functioning concerns may become an issue as a function of treatment in other components of the sexual health model. Clients' stories describe how many will turn to the Internet to obtain sexual information especially about sexual issues, acts, fetishes, or fantasies they may be uncomfortable discussing with others. It is important when addressing a client's lack of sexual knowledge to include information on all types of sexual behavior. In some cases, clients turn to online sexual behaviors due to sexual dysfunction.

Assignments in this stage include providing clients with information regarding sexual functioning, sexual fantasies, masturbation, pornography use, development of sexual skills, and possibly addressing sensate-functioning to address other barriers (e.g., shame, trauma, anxiety).

Sexual Health Care and Safer Sex

This component covers a broad perspective helping the client know and appreciate his or her body, administering regular self-exams and responding to physical changes with appropriate medical intervention. This component requires a client to examine his or her safer-sex behaviors. The clinician may need to provide education regarding HIV transmission or help the client develop tailored safer-sex interventions, including the possibility of harm-reduction techniques. Additional health issues need to be addressed, including the impact of smoking on sexual functioning. Two examples include how online behaviors might be attempts to engage in negotiated safety (Rosser et al., 2011), and gather information about health related information (Kubicek, Carpineto, McDavitt, Weiss, & Kipke, 2011), which may be of questionable quality (Kienhues, Stadtler, & Bromme, 2011). Rosser et al. also suggest how the Internet might be a venue for HIV-prevention education.

Challenges and Barriers to Sexual Health

The major challenges suggested by Robinson et al. (2002) (given their focus on HIV prevention), include mental health, sexual abuse, substance abuse, and compulsive sexual behavior. Clients need to be assessed for possible mental health and chemical dependency problems. The linkage between alcohol and drug behavior and problematic sexual behavior is well established.(Patrick & Maggs [2009] citing Cooper [2006], identified 600 studies investigating the association between using drugs and sexual behavior). The concepts of cross-addiction/compulsivity, and/or co-occurring disorders are relevant. Clinicians need to work with clients to help them complete the mental health and substance abuse assessments. The linkage between Internet and mental health is mixed. Cotten, Goldner, Hale, and Drentea (2011) suggest a highly nuanced relationship between timing and type of use. One

study in Switzerland suggests a "U" relationship between the amount of Internet use and perceived mental health (Bélanger, Akre, Berchtold, & Michaud, 2011). A possible linkage between Internet use and attention-deficit has been established in Taiwan (Yen, Ko, Yen, Wu, & Yang, 2007; Yen, Yen, Chen, Tang, & Ko, 2009), but could benefit from additional research.

There is a current emphasis on trauma in treatment of sexual compulsivity. On the Internet individuals may become curious about sexuality that was part of the abuse they suffered or maybe even curious about sexual images of children being abused. These are important conversations for the clinician to have with the client. The Sexual Health Model integrates trauma as part of the overall picture of the client. Assessment and, if necessary, treatment for trauma is part of the treatment process when using the sexual health model. As appropriate, clients will need to assess the impact of possible abuse on their sexual lives, including how it impacts their online sexual behavior. (e.g., Jacob & McCarthy-Veach, 2005).

Assignments in this component include a review of mood disorders and review of types of abuse and sexual violence. When appropriate, completing a trauma history and developing strategies for overcoming the impact of the trauma are required. Clients are also encouraged to complete drug and alcohol screens to determine if additional follow-up is necessary. Examining the relationship between cybersex behaviors and each of the possible barriers is relevant. As in many circumstances, what came first may be difficult to determine at the initial glance.

Body Image

A healthy body image requires challenging the notion of one narrow standard of beauty and encouraging self-acceptance. In order to achieve sexual health an individual needs to develop a realistic and positive body image. For some individuals who struggle with cybersex concerns, the use use of the Internet may contribute to body image struggles. The sheer numbers of "perfect" bodies online, and the search for the next perfect image is part of the online hunt. The Internet too often negatively impacts realistic perceptions of body type, size, and genital size.

Body image is impacted by other components of the model, including abuse and culture. It is necessary for the clinician to review with the client impact of abuse on body image (Smolak & Murnen, 2002; Treur, Koperdák, Rózsa, & Füredi, 2005). Gay men differ from straight men in holding distorted cognitions the ideal physique (Kaminski, Chapman, Haynes, & Own, 2005). Some cultures may have a protective factor regarding body image. Demarest and Allen (2000) suggest that Caucasian women are more likely to hold distorted perceptions than Black and Hispanic women. A decrease in sexual activity was associated with lower perceived attractiveness. (Koch, Mansfield, Thurau & Carey, 2005). For women, a healthy sense of body

image is associated with higher frequency of sexual behavior, greater level of comfort, comfort in undressing in front of partner, and frequency of experiencing orgasm (Ackard & Kearney-Cooke, 2000).

Assignments in this section include addressing one's body image and genital image. The previous paragraph highlights how some body image assignments may be addressed with examining the related cofactors.

Masturbation, Fantasy, & Sexually Explicit Material

All online behavior is fantasy based. Given the venue, whether it is chat, text, cam, or other cybersex behaviors, the missing data of the encounter are mediated through the power of thought. You not only see the picture, you make up a story of what the picture means. The story reflects fantasy. The linkage between masturbation and fantasy with online sexual behavior is easy to recognize. Less clear is the possible healthy role of masturbation and fantasy. Masturbation and fantasy can be a healthy expression of sexuality (Coleman, 2002). Clients need to clarify their values on these subjects, including addressing the shame and guilt associated with masturbation, relationship assumptions, and historical myths associated with sin, illness, and immaturity. Coleman describes healthy masturbation as linked with orgasmic capacity, healthy sexual functioning, sexual satisfaction in relationships, positive attitudes about sexuality, increasing comfort with one's body and self-esteem, and decreased anxiety in interpersonal sexual contexts.

It is also important for clients in chemical dependency recovery to undo the behavioral linkage between chemical use, masturbation, and sexual fantasy. For individuals in early recovery who used "party" drugs associated with sex, the behavioral conditioning between sex and drugs needs to be extinguished as a factor of chemical health recovery in additional to sexual health promotion. Morin (1996) highlights the power of sexual fantasies in understanding the unconscious/subconscious currents of clients' sexual beliefs. Given the fantasy content of cybersex, this is an important component to address in helping clients develop sexual health. Anecdotal stories demonstrating the relationship between the Internet and drug relapse appear significant. The ease of access to chemicals through online chat as a relapse trigger has yet to be studied.

It is also critical that clinicians assist clients in clarifying their beliefs about the use of sexually explicit material. The use of sexually explicit material is not without controversy. Two camps exist reflecting the dichotomy of sexually explicit material. One belief is that sexually explicit material is unhealthy (Maltz & Maltz, 2010). Other researchers suggest sexually explicit material is helpful in the promotion of sexual health (Rosser et al, 1995). It is important for each client to decide what is healthy for him or her. For some it may mean sexually explicit material is not a healthy choice, for others it may mean certain types of sexually explicit material are healthy and certain types

are unhealthy. It is often a decision that requires information and careful consideration.

Reflecting the ethical principles of autonomy, the assignments in this component are designed to help the individual clarify his or her values around masturbation, fantasy, and the use of sexually explicit material. Key to many of the components, developing the skills to communicate his or her values with his or her partner is included in these assignments.

Positive Sexuality

All human beings need to explore their sexuality in order to develop and nurture who they are within a positive and self-affirming environment. Positive sexuality includes appropriate experimentation, sensuality, sexual boundaries, and sexual competence developed through the ability to give and receive sexual pleasure (Robinson et al., 2002). In some cases cybersex behaviors might be a part of the discovery and experimentation. This section helps clients clarify motivations for sexual behavior, develop positive sexuality, affirming sexuality across the lifespan, and clarifying his or her individual preferences regarding sexual needs and interests, and frequency (Brick, 1991; Deacon & Minichiello, 1995; Leiblum, 2003; Meston & Buss, 2007). Ultimately, sexual health is the client taking responsibility to get his or her sexual needs met. In some cases, online behavior could be a form of harm reduction given the client's personal values and commitments. Consistent with the origins of the sexual health model (i.e., sexual attitude reassessment seminars), the clinician is challenged to be aware of his or her cultural assumptions of appropriate sexual behavior including developing competency (or, at a minimum, referrals) when addressing alternative sexualities (e.g., caras.ws)

Intimacy and Relationships

Taking many forms, intimacy is a universal need that people receive through relationships. Sexual health requires knowing what intimacy needs are important for the individual, and finding appropriate ways to meet these needs. Clinebell & Clinebell (1970) highlight 12 types of intimacy. Online behaviors may be both an attempt to cope with and/or cause of intimacy problems. Often clients will focus only on sexual intimacy, failing to recognize other forms of intimacy. Some clients will often use sexual behavior as the only way to get some of the intimacy needs met. Clients need to identify ways to get different types of intimacy needs met through healthy behaviors.

"What is a healthy relationship?" is an entire industry/field of study. A summary of that field is beyond the scope of this article. However, relationships are a major part of sexual health. Clients and their partners

will need to address relationship concerns, and the possible impact of cybersex behaviors on the relationship. It goes without saying that there are many types of relationships. The sexual health model affirms the client's ability to decide the type of relationship they want. While most individuals will choose a standard monogamy model of relationships, Easton and Liszt (1997) highlight a variety of relationships that some individuals might choose.

Assignments in this section start with the following: Types of Intimacy; The Language of Relationships; Relationship Satisfaction; Healing from Past Relationships; Steps in Building the Sexual Relationship; Types of Relationships; and Disclosure to Partners. Given the priority many individuals place on relationships, these assignments are often the beginning point. Individuals may need to engage in couples therapy as part of healing from the impact of online sexual compulsivity (Corley & Schneider, 2002; Schneider, 2005; Tripodi, 2006).

Spirituality and Values

The final component emphasizes consistency between one's ethical, spiritual, and moral beliefs, and one's sexual behaviors. This spirituality may include identification with a formal religion but doesn't necessarily have to. In some cases, the online behavior might be an attempt to overcome negative religious beliefs. However, one's beliefs always address moral and ethical concerns and deeper values in order to integrate a person's sexual and spiritual selves. In some cases, it might include a 12-step tradition (Carnes, 1992).

Assignments in this component include integration values and sexuality. In some cases, conflict between one's cultures may require a sense of healing and/or resolution of the perceived conflict. Consistent with motivational interviewing, when a client identifies his or her values, the desire to engage in behaviors consistent with those values will likely be higher.

NEXT STEPS

Many studies with promising results have examined the application of the sexual health model in reducing high-risk HIV sexual behavior (see Robinson et al., 2002). No published studies have been conducted regarding the application of the model in the treatment of problematic online sexual behavior. One quasi study addressing sexual compulsivity had mixed results, primarily due to methodological concerns (Edwards, 2009b). Future research will need to follow-up on the adaptation of the model to treating cybersex.

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