



v24 n1 Winter 2009

# FOCUS

## A Guide to AIDS Research and Counseling

## Describing and Treating Out-of-Control Sexual Behavior

John Giugliano, PhD

In the early 1980s, a group of psychotherapists noticed that their clients were reporting problematic sexual behaviors that they were unable to stop despite negative consequences. These clinicians began to meet and consult with each other to better treat these clients. In 1983, psychologist Patrick Carnes named this problem “sex addiction.”

### Compulsive, Impulsive, or Addictive Behavior?

The clinical literature on this phenomenon describes this behavior in various ways including: a compulsive disorder, an impulsive disorder, or an addiction. While there is considerable overlap between the clinical definitions of these concepts, there are also key differences.

Commonalities between compulsive, impulsive, and addictive (for example, substance dependent) behaviors include the presence of repetitious behaviors, difficulty resisting the behavior despite knowledge of potential adverse consequences, and the fact that behaviors may be triggered by both internal and external cues. Compulsive behaviors are driven by an effort to reduce the anxiety created by obsessive thoughts, rather than for pleasure or gratification.<sup>1</sup> Impulsions are unrelenting urges that demand immediate gratification and are acted upon without forethought of longer-range consequences. The difference between compulsive and impulsive behavior is that the goal of impulsive behavior is to experience pleasure, whereas the motivation underlying compulsive behavior is to prevent or reduce anxiety and discomfort.

Some clinicians link out-of-control sexual behaviors to obsessive-compulsive disorders.<sup>2</sup> Although acting out sexually can relieve pain and anxiety, the undoing of a distressing obsession is the function of classic compulsive behavior. Since most individuals who experience out-of-control sexual behaviors derive some pleasure from these behaviors, the term “sexual compulsivity” is not consistent with the definition of compulsions in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*,<sup>1</sup> and some researchers contend that such behavior would be better described as an “Atypical Impulse Control Disorder.”<sup>3</sup>

Yet, according to the *DSM-IV-TR*, “the essential feature of Impulse-Control Disorders is the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or others.”<sup>1</sup> While this description could apply to out-of-control sexual behavior, the *DSM-IV-TR* also states that the term “impulse control disorder” cannot be used to refer to symptoms that are part of the presentation of other disorders.

The concept of “addiction” may be preferable to describe out-of-control sexual behavior—as it denotes a behavior pattern designed to produce pleasurable emotions and to provide a means for the evasion of painful internal states, or both.<sup>4</sup> Yet, although the term “sexual addiction” was mentioned in two places in an earlier manual (the *DSM-III-R*), neither “sexual addiction” nor “addiction” appears in the *DSM-IV-TR*. Disorders involving substances are described in the *DSM-IV-TR* with more specific terms such as “dependence” and “abuse.” Uncontrollable habitual gambling is diagnosed as “pathological gambling” rather than an addiction because it has been argued that the term addiction is too broad and therefore imprecise.

To be consistent with the current terminology of the *DSM-IV-TR*, this article will

# Editorial: Drawing the Line

Michelle Cataldo, LCSW, Clinical Editor

Last summer, actor David Duchovny announced that he was receiving treatment for sex addiction at a rehabilitation facility. The news stirred up the familiar debate about sex addiction: is it a real disorder, an excuse for irresponsible behavior, or a way of pathologizing normal human impulses?

Even the psychotherapeutic community is divided on the topic of out-of-control sexual behavior. Various called sexual compulsivity, impulsivity, addiction, or dependence, this problem has not yet found its place in the *Diagnostic and Statistical Manual of Mental Disorders*. This lack of precisely defined criteria complicates discussions of prevalence, assessment, and treatment.

Critics of the categorization voice concerns about the overmedicalization of everyday life, and about the ways that psychiatric language has been used to control “disorderly” sexuality, for example, by its past labeling of

homosexuality as a “sexual orientation disorder.”

Proponents of the diagnosis point to the discovery that the “pleasure centers” of the human brain respond similarly to both behavioral (gambling, shopping, eating, sexual) and substance (alcohol and other drugs) addictions. They further argue that only those who experience significant impairment as a result of their condition should be considered “out of control.” What is needed, they say, is more research to better define the phenomenon and alleviate the pain of sufferers.

But perhaps the most important question for those who work in the HIV prevention field is how to help people who believe that their sexual behavior is out of control feel a greater sense of personal power to make “healthy” sexual choices: choices that are in alignment with their own values, that do not harm themselves or others, and that reduce their risk of acquiring or transmitting HIV.

The articles in this issue begin to

answer this question, and another: when is “risky” behavior not related to HIV risk at all? Although many people experience negative consequences as a result of their out-of-control sexual behaviors, several of these behaviors are unrelated to the likelihood of HIV transmission. In his article, John Giugliano walks us through the controversy surrounding how to best clinically describe the phenomenon of out-of-control sexual behavior. He then describes the therapeutic approaches that may be most helpful to clients at each stage of the problem. In his article, Christian Grov explores the impact of the internet and its buffet of sexual possibilities on out-of-control sexual behavior and HIV risk.

Although many of the details of the discussions regarding the forthcoming edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* have not been released to the public, some clinicians have proposed categories describing both sexual and internet addiction. Scheduled to be published in 2012, this new manual should help clinicians, insurers, and clients draw these lines more precisely amid the controversy over diagnosing behaviors that feel out of control. ■

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use the term “sexual dependence” when describing any repeated sexual behavior that an individual reports being “out of control,” together with repeated unsuccessful attempts by a person to stop the behavior, despite impaired functioning and vocational, legal, health, relational, physical, or emotional consequences. While not a perfect descriptor, “sexual dependence” is preferable to other terms in use because successful treatment often follows a course that is similar to treatment for substance dependence.

## An Assortment of Approaches

Without clear clinical criteria and definitions, making a definitive diagnosis of a client experiencing sexual dependence is difficult, if not impossible. Published treatment models for and research on the treatment of sexual dependence are very limited, so ther-

apists who acknowledge sexual dependence as a disorder often borrow models used to treat substance dependence. These include a potpourri of approaches: education and spiritual development; support groups and group therapy; individual therapy; conjoint therapy; cognitive behavioral techniques; family therapy; and 12-step programs.

As is the case with many disorders, people suffering from sexual dependence may benefit most from a biopsychosocial approach to treatment. Psychotherapists should refer clients for medical assessment, since antidepressants (including tricyclics and serotonin enhancers) have been quite effective in treating some individuals.<sup>5</sup> Interestingly, people suffering from sexual dependence seem to respond to antidepressant treatment in different ways than individuals with Obsessive-Compulsive Disorder, further

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suggesting a distinction between the two.<sup>6</sup> Other medications used to treat sexual dependence include those to diminish sex drive (such as anti-androgenic, progestational agents) and to improve control over impulses (such as anti-anxiety agents).

Psychotherapeutic interventions are divided into two phases. The first are those used in the “active phase” in which the client is still engaging in out-of-control sexual behavior, and are focused on stabilizing the client. The second are those employed in the “second phase,” during which the client experiences what might be thought of as “sexual sobriety,” and these interventions address the issues underlying the sexual dependence.

### Stabilizing the Client

While clinicians must name and address the problem sexual behaviors early in treatment, it is essential to build a rapport and a therapeutic alliance with the client before engaging in confrontation. Motivational interviewing techniques, borrowed from substance abuse treatment, can help clients address the ambivalence they are likely to feel around changing their behavior.

Cognitive-behavioral techniques are a critical part of treatment. Most clients have strongly conditioned associations in which people (for example, former sexual partners), places (such as internet hook-up sites, bars, or other cruising venues), or emotions (such as anxiety, loneliness, or frustration) trigger their acting-out behavior. Identifying these triggers, selecting coping strategies (including avoiding triggering situations when possible), breaking the associations between the triggers and the acting-out behavior, and creating self-statements that support sobriety all help the client stabilize his or her behavior. These cognitive-behavioral techniques offer a bridge to the second phase of treatment, and are helpful in assist-

ing clients to build new associations and prevent relapse.

In addition to psychoeducation and cognitive-behavioral techniques, a variety of social support and environmental interventions

can help clients achieve sexual sobriety. These resources include inpatient rehabilitation and 12-step programs that have been adapted from Alcoholics Anonymous for the benefit of sexual addicts. These groups support clients in confirming the nature of their problem and relieving shame as the groups provide social support, emotional release, and sustain hope for recovery. They also offer suggestions for alternate responses to triggering situations, and a place to turn when the client is afraid that he or she will engage in out-of-

control sexual behavior and the client’s therapist is not available.

Individual treatment can take place concomitantly with a 12-step program or begin after a period of sobriety. Although self-help groups contribute enormously to recovery, sobriety alone does not cure the deficits in the self that are at the root of sexual dependence. Once sobriety has stabilized, the second phase of treatment strives to remediate these deficits by working through psychodynamic issues in individual treatment.

### Moving Deeper

Once the client has stopped acting out sexually, successful relapse prevention planning and true recovery demand greater insight into the dynamics of the client’s dependence. At the root of this disorder lie problems with early trauma, intimacy, and attachment, so early disruptions in relationships must be examined by the client and the therapist.<sup>7,8</sup> A clinician using an object relations model during the second phase would explore how a client responds to abandonment, rejection, and closeness, and help the client make steps toward more adaptive responses.

While successful treatment often utilizes a variety of appropriate theories, Kohut’s self-psychological approach may be particularly

*Most people who engage in out-of-control sexual behavior do so as a means of numbing themselves from a pain or anxiety that feels more immediate than concerns about acquiring or transmitting HIV.*

useful. Most people who suffer from sexual dependence do not have a sense of their own worth or wholeness, usually because these were not adequately reflected or “mirrored” for them as children. This can result in an unhealthy narcissism, in which the individual’s grandiosity and sense of entitlement masks an insecurity resulting from the repression of early needs. Narcissistically disturbed individuals lack the inner resources to supply themselves with esteem and approval—or to “self-soothe” in difficult or anxiety-producing situations.<sup>9</sup> As a result, sexually dependent people yearn for admiring and mirroring responses from others—and may find temporary fulfillment of these desires through sexual activity.

Like other narcissistically injured individuals, people who suffer from sexual dependence have difficulty maintaining functional and intimate relationships. Psychotherapy offers an opportunity for a relationship in which another person (the therapist) can counter the client’s feelings of worthlessness, soothe emotional disruptions, and calmly reflect an acceptance of the client and the client’s wholeness. Through the therapeutic relationship, the client feels safe enough to let go of his or her grandiose defenses and become more available to emotionally intimate relationships.

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## The HIV Connection

There is an imperfect relationship of out-of-control sexual behavior and HIV risk. Problematic sexual behavior can take many forms ranging from unprotected anal sex with multiple partners to habitual masturbation while viewing internet pornography. Yet many of these behaviors do not result in any health risk—or even physical contact with others.

Any assessment of a client who is acting out sexually should include an exhaustive examination of the current and potential negative consequences of the addictive behavior—including the risk of acquiring or transmitting HIV—and assessment of the client’s understanding of HIV risk behaviors and prevention methods. In addition, after an acting-out episode, the therapist can ask the client if the encounter presented HIV risk and if condoms were used, and can encourage the client to be tested for HIV, if appropriate.

Many clients, particularly those living with HIV, are well-informed about HIV risk

behavior, but this knowledge does not prevent them from engaging in such behavior because this condition is defined by lack of control over behavior. Most people who engage in out-of-control sexual behavior do so as a means of numbing themselves from a pain or anxiety that feels more immediate than concerns about acquiring or transmitting HIV. It is also important to emphasize that clients often have severe, life-threatening consequences to this disorder that are unrelated to HIV risk: other illnesses, injuries, homelessness, unemployment, bankruptcy, and loss of partners, family child custody, and reputation are common if the individual remains untreated.

Although a healthy sexual engagement is the ultimate goal for treatment, abstinence is recommended initially. However, in cases in which it is clear that the client cannot totally abstain initially, harm reduction methods may be employed. Encouraging clients to use condoms, to seek HIV and other STD testing and treatment as needed, to switch from anal or vaginal sex to oral sex, or to place a moratorium on new partners (without giving up current partners) are all possible interventions. In this situation, the therapist develops an understanding of the hierarchy of the client’s risks for HIV and works from the top to help the client reduce these risks. This is similar to the triage process that the clinician uses to sort out priorities when a client suffers from multiple disorders, such as substance abuse, other mental health issues, or HIV. Whichever problem appears to be causing the most negative consequences to the client must be addressed first.

## Conclusion

Gaining a healthy control over sex, like gaining healthy control over eating habits, is perhaps more difficult than gaining control over abused substances, since drugs of abuse can be eliminated entirely, while sex and food are part of a healthy life. One must learn a healthy way of living with sex, rather than eliminating it altogether.<sup>10</sup> Ultimately, the goal of treatment is a healthy self-concept and sexuality that brings pleasure, intimacy, and fulfillment without negative consequences to self or others. Therapists can help clients confront their fears about what might happen if they allow themselves to integrate healthy sexuality in their lives by helping them to learn how to “let go” without being “out of control.” ■

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# Sexual Compulsivity, the Internet, and HIV: A Focus on Gay and Bisexual Men

Christian Grov, PhD, MPH

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Sexual compulsivity, also known as sexual addiction, is characterized by sexual fantasies and behaviors that are frequent and intense enough to interfere with personal, interpersonal, or vocational pursuits.<sup>1</sup> Sexual compulsivity can result in interpersonal conflict and distress, social and occupational problems, psychological distress (especially damage to self-esteem), and financial problems.

Over the past two decades, research interest in the phenomenon of sexual compulsivity has grown, in part because of concerns that “out-of-control” sexual behavior may be linked to risk for acquiring and transmitting HIV. During the last decade, researchers have also begun to explore the role of internet use in facilitating HIV risk-related behavior. With studies reporting that 40 percent to 66 percent of men who have sex with men seek sex partners online, it is clear that the internet provides an increasingly common means of sexual connection, often surpassing venues such as bathhouses, gay bars and clubs, private sex parties, gyms, or public cruising venues.<sup>2,3</sup> It seems intuitive that when men who experience out-of-control sexual behavior use technology that allows them to meet sexual partners quickly and easily, HIV risk may be increased, but much about the true nature of the interaction between sexual compulsivity, the internet, and HIV risk in the lives of gay and bisexual men remains unclear.

While researchers have documented the association between sexual compulsivity and HIV risk, and have investigated the association between the internet and HIV risk, only recently has research begun to focus on the overlap of sexual compulsivity and internet use as related to HIV risk. This article explores the links between sexual compulsivity and HIV risk, discusses why these links may be especially significant for men who have sex with men, and examines the role of the internet in both facilitating and curtailing HIV risk among sexually compulsive gay and bisexual men.

In exploring these links, it is important to avoid pathologizing either sexual activ-

ity itself (including sex outside of committed relationships) or seeking sexual and romantic partners online. Rather, the focus of this article is the beginning exploration of problematic internet use by individuals with a compulsive sexual disorder.

## Compulsivity Among Gay and Bisexual Men

Without clear diagnostic criteria, it is difficult to estimate the prevalence of sexual compulsivity, but some researchers have suggested that it lies between 3 percent and 6 percent in the general population, with a higher prevalence among men than women.<sup>1</sup> Some researchers have suggested that rates are higher among gay and bisexual men,<sup>4</sup> and a City University of New York community-based survey of 1,214 gay and bisexual men in New York City found that 30 percent reported symptoms of sexual compulsivity.<sup>5</sup>

It is unclear why rates of sexual compulsivity may be higher among gay and bisexual men. The high rate of child sexual abuse among those with sexual compulsivity and the marginalization of gay sexuality and relationships are possible factors.<sup>6</sup> In addition, gay men typically report more sexual partners and have access to a greater variety of sexual venues than do other people.<sup>6</sup> These increased opportunities for sex may allow gay and bisexual men who are already predisposed to sexual compulsion to actually engage in behavior that could lead to the development of the disorder. This is similar to the finding that increased access to gambling opportunities is related to a rise in the incidence of pathological gambling.

Sexual compulsivity has been consistently associated with HIV risk behavior in both heterosexual and gay male samples. Compared with men not experiencing symptoms of sexual compulsivity, researchers have found that sexually compulsive gay and bisexual men are less likely to disclose their HIV serostatus to sexual partners,<sup>7</sup> and that they report lower capability of using a condom during sexual encounters.<sup>8</sup> The City University of New York study cited above found that HIV-positive participants, as well as those who reported sex under the influence of drugs within the prior 90 days, reported significantly higher scores on measures of sexual compulsivity. Men who identified as “barebackers” (people who intentionally seek unprotected anal sex) also reported significantly higher sexual compulsivity scores.<sup>5</sup> Higher sexual compulsivity

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scores were also significantly related to higher scores on a measure of the degree to which participants felt tempted to have unsafe sex.

### Where's the Risk?

Because rates of sexual compulsivity appear to be higher among men who have sex with men, and because some researchers suggest that men who seek sex online may be at increased risk for acquiring or transmitting HIV, the question arises: is there a significant relationship between sexual compulsivity, internet use, and HIV risk for men who have sex with men? Preliminary research on the subject has produced mixed results.

Between 2002 and 2003, the research team at the Center for HIV/AIDS Educational Studies and Training in New York conducted Project SPIN, interviewing 183 gay and bisexual men who were experiencing symptoms of sexual compulsivity.<sup>6,9</sup> Though the internet was not the focus of Project SPIN, it emerged as a significant theme in men's reports of their compulsive behaviors.

Drawing from the data from Project SPIN and other studies, below are three ideas about the ways that sexual compulsivity, the internet, and HIV risk may interact in the lives of gay and bisexual men. These ideas highlight both the risky and protective aspects of internet use. None of the dynamics is mutually exclusive, and several may operate simultaneously for any given person.

*The Internet as a Facilitator and Trigger for Sex and Sexual Compulsivity.* Clearly, the internet facilitates sexual contact by allowing people to meet potential partners quickly and easily. In Project SPIN, some men reported that they had a pre-existing

problem with sexual compulsivity, and the internet was simply the tool they used to identify and meet partners. Had the internet not been available, they could have turned to another source for partners, such as visiting a bathhouse. SPIN participants highlighted how the internet "replaced" more traditional venues (such as bathhouses and public cruising spots) where they had previously engaged in sex and enacted their sexually compulsive episodes.

In contrast, some Project SPIN participants reported that the internet sparked additional sexually compulsive behavior. Some of these men indicated that the persistent availability of the internet (unlike bars, bathhouses, and public cruising areas, which had more defined hours of "operation") allowed them to engage in sexually compulsive behavior more often, whereas time-limited venues would have curtailed them.

Some men felt triggered to act out when checking their e-mail and seeing a message from a previous sex partner, which resulted in back-and-forth dialogue that eventually led to a compulsive episode (either with that partner or with others). Others viewed online pornography or engaged in cybersex ("virtual" sex where the encounter is confined to online communication), which increased their arousal and led them to search for and meet partners off the internet.

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### Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to [rob.marks@ucsf.edu](mailto:rob.marks@ucsf.edu) or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

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In contrast, while many men described compulsive, internet-related sexual behavior that caused them and others painful negative consequences, much of this behavior was not inherently linked to HIV risk. Rather, they spent such a significant amount of time looking for sex or viewing pornography that they neglected important social responsibilities. These men referred to the internet as a “black hole” that consumed all their time.

*The Internet as a Facilitator for HIV Risk.* Research to support the contention that the internet is related to HIV risk is mixed. One 2006 meta-analysis examined 22 studies of online sex-seeking among men who have sex with men. The researchers reported that men who sought sex online were more likely than men who did not to report unprotected anal intercourse.<sup>3</sup> It is unclear, however, whether the instances of unprotected sex occurred with the partners that study participants met online.

Other reviews of HIV research note that while some studies have linked internet use to HIV risk, others have not.<sup>10</sup> One 2004 study found no differences in rates of unprotected anal intercourse between men who met their partners exclusively offline and those who met partners exclusively online, while those who met partners both online and offline were the most likely to also report HIV risk behaviors.<sup>11</sup>

Research methodology may make a difference. One 2007 study found that when participants were asked to recall their past behavior, a history of online sex-seeking was associated with greater numbers of sexual partners in the prior year, greater likelihood of one-time sex partners, greater likelihood of sex without condoms, and more frequent failure to discuss partners’ sexual histories. In contrast, when the same respondents used daily diaries to record their sexual behavior, unprotected anal intercourse was less likely to occur with partners met online than with partners met by other means.<sup>12</sup>

One way that the internet may increase HIV risk is by expanding sexual networks, allowing men who might not have otherwise met to connect. One 2008 study of 2,312 men who have sex with men found that those who met partners online had significantly more sex partners within the previous year than men who did not meet their sexual partners online.<sup>13</sup> Network expansion can also expose men to ideas

and norms they may not have otherwise encountered. For example, the growth in the popularity of both the “barebacking” identity and “party-n-play” activities (drug-enhanced sex often involving the use of methamphetamine) have been linked to the internet.<sup>11,14</sup>

*The Internet as a Facilitator for Harm Reduction.* The internet can also facilitate harm reduction. Just as men can search for partners willing to participate in behaviors such as barebacking or party-n-play, users can also search specifically for partners of the same HIV status or partners who are interested in protected sex only or other lower-risk practices such as oral sex.<sup>10</sup>

Cybersex can replace “real” sex, such that men could use online pornography (or cybersex) and masturbate at home, quelling the urge for sex with a “real” partner (and eliminating HIV risk altogether).<sup>9</sup> Some participants stated that they would have sex with a single partner when using the internet (versus multiple sex partners during the course of a multi-hour visit at a bathhouse).

While the possibilities for using the internet as a tool for HIV and other STD prevention and care are wide and varied, most of its potential lies unexplored. Partner notification services via the internet are an exception, offering one successful example of online sexually transmitted disease prevention and care.

## Conclusion

Despite what appears to be a large overlap between men who experience sexual compulsivity and men who seek sexual partnership or gratification online, to date, there are no empirically validated computer-based interventions that specifically target those who engage in sexually compulsive behavior. Indeed, thus far, there has been little empirical validation that effective behavioral interventions can be delivered via the internet. The variety of offline interventions to treat sexually compulsive behavior includes 12-step group membership, medication, cognitive-behavioral interventions, and psychodynamic treatments. Given that sexual compulsivity is more prevalent among gay and bisexual men, and that many gay and bisexual men use the internet for sex-related activities, it is essential to improve our understanding of how to deliver effective online interventions to this population. ■

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ISSN 1047-0719



## Related Resources

### Journal Articles

**Bancroft J. Sexual behavior that is “out of control”: A theoretical and conceptual approach. *Psychiatric Clinics of North America*. 2008; 31(4): 593–601.** Notes that most of the theories about the functions that out-of-control sexual behavior serves (such as anxiety reduction or mood regulation) are the result of clinical impressions rather than reported data. Focuses on how and why sexual behavior comes to be “out of control” and postulates that there are a variety of causal mechanisms for this phenomenon. Examines several different ways of conceiving of out-of-control sexual behavior, including engaging in such behavior as a response to negative mood states, as a result of impaired inhibition of sexual arousal, as a failure of self-regulation, as an addiction, and as a manifestation of obsessive-compulsive disorder.

**Bancroft J, Vukadinovic Z. Sexual addiction, sexual compulsivity, sexual impulsivity, or what? Toward a theoretical model. *The Journal of Sex Research*. 2004; 41(3): 225–234.** Discusses the theoretical bases for labeling out-of-control sexual behavior as compulsive, impulsive, or addictive. Reports on the findings of a small Kinsey Institute study comparing self-defined “sex addicts” with age-matched members of the control group. Researchers found that those who defined themselves as sex addicts were significantly more likely than those who did not to report that they experienced increased sexual interest while anxious or depressed, and that the vast majority in the sex addicts group reported an increased likelihood of acting out when experiencing either depression or anxiety. Discusses how variations in sexual excitation and inhibition during negative mood states may relate to out-of-control sexual behavior.

**Klein M. Sex addiction: A dangerous clinical concept. *Electronic Journal of Human Sexuality*. 2002; 5: 1–7.** Psychotherapist Klein argues that the assumptions underlying the sexual

addiction model are not aligned with a healthy concept of human sexuality. He notes the subjectivity of many of the criteria used by the Sexual Addiction Screening Test in particular, and states that the sexual addiction model pathologizes non-problematic behavior (for example, frequent desire for partner sex or masturbation). He also critiques the model as insufficiently concerned with differential diagnosis and as part of a larger group of conditions such as nymphomania, frigidity, and homosexuality that he argues have been used as a means of social control.

### Web Sites

**Society for the Advancement of Sexual Health (SASH). <http://www.sash.net/>.** Provides information and supports education and research on out-of-control sexual behavior. Site contains a network directory of professional help and mutual-help groups. Conducts education for the public, therapeutic professionals, and recovering individuals. The SASH peer-reviewed journal, *Sexual Addiction and Compulsivity*, is published quarterly. ■

## Next Issue

In our Spring issue, **Julie Kraut-Becher, PhD**, and **Marlene Eisenberg, PhD**, both Research Associates in the HIV Prevention Division of the University of Pennsylvania, and **Sevgi O. Aral, PhD**, Associate Director of Science, Division of Sexually Transmitted Diseases Prevention, U.S. Centers for Disease Control and Prevention, examine the multiple hypotheses for the tremendous disparities in HIV infection rates between Black and White Americans.

Also in the Spring issue of *FOCUS*, **Jennifer Alvidrez, PhD**, and **Sita Patel, PhD**, discuss the stigma experienced by Black Americans who seek mental health treatment. They also identify the positive coping strategies exhibited by those who successfully obtain treatment.