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Healthy Sexual Practices: Counseling Approaches for Differentiating Typical and Atypical Sexual Behavior in Adults

Amber L. Pope, Old Dominion University and Ben T. Willis, University of Scranton

HEALTHY SEXUAL PRACTICES

Historically, sexual health has been primarily considered with respect to physiological well-being and from the aspect of adverse health outcomes (e.g., HIV/AIDs, sexual abuse; Anderson, 2013; Burnes, Singh, & Witherspoon, 2017). Since the early 2000s, there has been an increased focus on sexual health from the holistic frameworks of positive sexuality and sex-positivity, which emphasize sexual satisfaction, pleasure, self-efficacy, and the integration of physical, emotional, relational, intellectual, developmental, cultural, and contextual aspects of sexuality and sexual practices (Anderson, 2013; Burnes et al., 2017; Murray, Pope & Willis, 2017).

The World Health Organization (2019, para. 1) has one of the most widely accepted definitions of *sexual health* as “a state of physical, mental, and social well-being concerning sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.” Recent models emphasize sexual health as a human right, access to information, values, autonomy, responsible decision-making, respect, vulnerability, intimacy, sexual expression, relational boundaries, spirituality, and the rejection of negative sexual attitudes and shame (Southern, 2017a, 2017b).

Guidelines for Healthy Sexual Behavior

Given the complex and multifaceted nature of sexual health, professional counselors may face challenges in differentiating healthy sexual practices from atypical sexual behavior. The Sexuality Information and Education Council of the United States (SIECUS, 2004) and the Society for the Advancement of Sexual Health (SASH, 2019) offer guidelines for healthy sexual behavior to include:

- Affirming sexual development as a part of human development
- Appreciating one’s body
- Seeking information about relationships, reproduction, and other sexuality-related topics
- Affirming and respecting diverse gender identities and sexual orientations
- Taking responsibility for one’s sexual choices and behavior
- Preventing harmful consequences of sexual practices for oneself and others
- Appropriately expressing love and intimacy to develop meaningful relationships
- Using critical thinking and decision-making skills concerning sexual behavior
- Communicating openly and directly with family, partners, and peers about sexuality
- Conveying sexuality as in congruence with one’s values
- Enjoying sexual feelings without always acting on them

Resources:

World Health Organization Sexual Health webpage: https://www.who.int/topics/sexual_health/en/

SIECUS Guidelines for Comprehensive Sex Education:

<https://siecus.org/wp-content/uploads/2018/07/Guidelines-CSE.pdf>

Ethical Sexual Behavior

Professional counselors can use guidelines for ethical sexual behavior as a starting point for identifying healthy versus atypical sexual practices. There are six main principles of intimate ethics (Darling & Mabe, 1989; Southern, 2017a):

- *Choice*: Also termed noncoercion, is individuals' ability to determine whether, when, and how they want to engage in sexual activities.
- *Autonomy*: Respect for others' self-determination and not treating others as a means to an end for sexual gratification.
- *Responsibility*: Being accountable for one's sexual behavior and avoiding engaging in sexual practices harmful to themselves or others. Includes non-deceit, being honest, and not withholding information from partners that diminishes their choice and autonomy to engage in sexual activities.
- *Respect for other's beliefs and differences*: Not seeking to change or influence others' sexual values or healthy sexual variations.
- *Allowance of the freedom to change*: Promotes sexual flexibility and fluidity throughout the lifespan, and acknowledges that consent can change from moment to moment or encounter to encounter.
- *Reversing sex negativity*: Engaging in behaviors intended to reduce the shame, stigma, and pathologizing of sex, particularly behaviors and identities that fall outside of the heteronormative, monogamous context (Southern, 2017a). An example of reversing sex negativity would be helping parents respond to a child's masturbation behavior by responding calmly, educating the child on their body parts, and providing the appropriate space and time for self-exploration (e.g., privately, in their bedroom).

Healthy Sexual Variations

Healthy sexuality comes in many forms, including varying sexual/affectional orientations, relationship configurations, and diverse sexual activities. Social discourses influence what individuals deem "normal" sexual behavior, and these norms change across time and cultures. In the United States, sexual behaviors which do not occur within opposite-sex, two-person (married) relationships tend to be stigmatized. *Heteronormativity* is a system that endorses heterosexuality and binary gender identities as normal and devalues identities that are non-heterosexual and non-cisgender (Herz & Johansson, 2015). However, there is a range of sexual orientations including asexual, bisexual, demisexual, gay, heterosexual, lesbian, omnisexual or pansexual, queer, and questioning (Murray et al., 2017), all of which are sexually healthy. Professional counselors should not pathologize individuals struggling with their sexual orientation, instead recognizing the issue is in the societal denouncement of their identities (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013).

Moreover, *mononormativity* is a viewpoint that promotes normal romantic and sexual relationships between two partners (Cassidy & Wong, 2018). Sexual activities, however, can occur solo, on a one-night stand, on a first date, with a friend, with a committed partner, with several partners, in monogamous relationships, and in non-monogamous relationships (Conley, Piemonte, Gusakova, & Rubin, 2018; Mark, Garcia, & Fisher, 2015). Multiple forms of consensual non-monogamous (CNM) relationships exist, including polyamory, open relationships, swinging, and monogamous relationships (Conley et al., 2018). Sexual activities in any of these relationship configurations are healthy, as long as partners are adhering to ethical sexual behavior practices with their partners.

There are a wide range of sexual behaviors including masturbation, kissing, petting, sexual fantasy, sexual talk/conversation, use of sex toys, watching pornographic material, anal sex, hand or manual sex, oral sex (cunnilingus and fellatio), and vaginal sex (often called sexual intercourse) (Mark et al., 2015; Schoenfeld, Loving, Pope, Huston, & Stulhofer, 2017; Walton, Lykins, & Bhullar, 2016). Individuals can engage in sexual activity solo, with a partner, or with two or more people at the same time. *Kink*, less common or unconventional sexual practices intended to heighten the intimacy between partners, also tends to be pathologized in U.S. culture (Yates & Neuer-Coburn, 2019). Kink includes practices such as bondage and

discipline, dominance and submission, sadism and masochism (BDSM), role plays, fetishes, sex games, and other forms of erotic expression, all healthy sexual practices when between consenting adults.

As explored in this section, healthy sexual expression is a nuanced process unique to each individual based on their sexual identity, desires, behaviors, and relationship configurations. Healthy sexual practices cover a wide range of sexual activities, as long as the activities meet the guidelines of ethical sexual relationships and healthy sexual behavior. As such, professional counselors should consider their beliefs about “normal” sexual practices to prevent imposing sexual values on clients who have varying sexual behaviors.

Professional counselors might have biases toward what represents a “normal” amount or type of sexual activity that may or may not be accurate to what is common among adults. The following information provides perspective on what individuals report regarding the frequency of sexual behaviors. Heterosexual individuals report engaging most frequently in vaginal sex, at a rate of eight times per month, when compared to other types of sexual behaviors (Graham, Catania, Brano, Duong, & Canchola, 2003; Rubin & Campbell, 2012; Velten & Margraf, 2017). A study of monogamous and consensual non-monogamous persons (e.g., swingers, a form of consensual non-monogamy), reported engaging in sexual activities the most frequently at an average of 4.15 times per week, or over 16 times per month (Conley et al., 2018). All other types of consensual non-monogamous and monogamous individuals were roughly the same average of 12 sexual activities in a month (approximately 3/week). While non-heterosexual frequency data is significantly less reported, estimates for lesbian women indicate having sex approximately 4-5 times per month (Scott, Ritchie, Knopp, Rhoades, & Markman, 2018), and some researchers have noted lesbian women having sex less often than heterosexual females (Solomon, Rothblum, & Balsam (2005). Findings for gay men indicating engaging in sex at roughly the same frequency as heterosexuals (Solomon et al., 2005).

Typically, people regardless of affectional/sexual orientation would like to engage in partnered sexual activity more frequently than they do (Scott et al., 2018; Velten & Margraf, 2017; Willoughby, Farero, & Busby, 2014). This may lead people to engage in masturbation. Over 50% of men report masturbating more frequently, at least 1-3 times a month and sometimes weekly, whereas the majority (over 60%) of women report never masturbating or less than once a month (Velten & Margraf, 2017). Men also use pornographic materials more frequently than women, with over 70% of men viewing pornography at least once a month, while approximately 64% of women report never using pornography (Poulsen, Busby, & Galovan, 2013). Pornography use also varies by age and relationship status. Older adolescents and young adults have higher rates of viewing pornography. In a college study sample aged 18-26 years old, 87% of men and 31% of women acknowledged using pornography (Carroll et al., 2008). Individuals in committed romantic relationships, however, report less frequent use of pornography than single people (Poulsen et al., 2013).

Resources:

Counseling the Kink Community: <https://digitalcommons.unf.edu/jcssw/vol1/iss1/4/>

Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling:

<https://algbtic.org/resources/>

Seven Forms of Non-Monogamy: <https://www.psychologytoday.com/us/blog/the-polyamorists-next-door/201407/seven-forms-non-monogamy>

Atypical Sexual Behaviors

Atypical sexual behaviors are deviations from the guidelines for healthy sexual practices, which are developmentally inappropriate, distressful to the individual, or harmful to oneself or others (National Center on the Sexual Behavior of Youth, 2019). In children, problematic sexual behaviors are those that are developmentally or culturally inappropriate, persistent, and continue after the adult corrective intervention, which typically involves other persons (Kellogg, 2010). Examples include normative

behaviors occurring at a much greater frequency (e.g., touching genitals for several hours a day) or causing distress or involving coercion of another child into participating. For this Practice Brief, we focus on atypical sexual behaviors in adults, which can include paraphilias, coercive sexual practices, and compulsive sexual behaviors and hypersexuality (Southern, 2017b).

Paraphilias. A paraphilia is “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners” (American Psychiatric Association [APA], 2013, p. 685). There are dozens of paraphilias that are individuated by the type of interest an individual has. Examples include fetishism (sexual interest in a non-genital body part or any inanimate object), sadism (sexual interest in hurting, threatening, and/or humiliating someone else), masochism (sexual interest in receiving pain, threats, and/or humiliation from someone), bestiality (sexual interest in animals), and voyeurism (sexual interest in watching someone get naked or engage in sexual behaviors without that person knowing). These interests and desires may or may not be harmful. When these desires are intense and persistent, present for at least six months, and causing the individual clinically significant distress and/or impairment, the symptoms can meet criteria for a *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013) diagnosis of a paraphilic disorder. Additionally, even if the desires are not distressing to the individual, the paraphilias can be diagnosed if the individual has acted on their desires with a nonconsenting person or if their actions have the potential to harm others. Some of the paraphilic behaviors are actually illegal (e.g., watching an unsuspecting person undress or engage in sexual behaviors, exposing one’s genitals to unsuspecting people, hurting someone who is not consenting) and can lead to imprisonment or other legal sanctions (Moser, 2019). The sexual behaviors in fetishistic, transvestic, sexual sadism, and sexual masochism disorders, however, can be done with a consenting partner(s), without distress/impairment and with significant pleasure for self and partner. Therefore, some paraphilic behavior, although unconventional, may fall within the range of healthy sexual practices.

Resources:

Kafka’s (2009) review of Paraphilias Not Otherwise Specified:

http://www.antonioacasella.eu/archipsy/KAFKA_2009.pdf

Compulsive sexual behaviors, hypersexuality, and sex addiction. Recently, there has been a significant discussion on adding a diagnosis to the DSM on psychological symptoms related to the behaviors and desire of engaging in sexual activity on a persistent basis (Carnes & Love, 2017; Kafka, 2010). This has created some professional arguments around what is too much sexual activity and what would meet the criteria for a mental health diagnosis. Recently, the World Health Organization added Compulsive Sexual Behavior Disorder as a diagnosis in the 11th version of the *International Classification of Diseases* (ICD-11), although a specific diagnosis has yet to be added to the DSM. Many mental health professionals are advocating for adding a diagnosis of “hypersexual disorder” (Kafka, 2010), “sexual compulsivity” (Coleman, 1987) “compulsive sexual behavior disorder” (Kraus et al., 2018), or “sexual addiction” (Phillips, Hajela, & Hilton, 2015). The DSM does have sexual dysfunction diagnoses for males and females that have low or no sexual interest (APA, 2013). Part of the controversy is connected to there being no definitive amount or frequency of sexual activity that is related to what is and is not healthy (Conley et al., 2018; Graham et al., 2003; Velten & Margraf, 2017).

Since there is lack of a clear amount of what is “too much” sexual activity, professionals have highlighted that people can be distressed by feeling a need to engage in sexual activity that can provide a rationale for the diagnosis. Kafka (2010) and Coleman (1987) have pointed to an impulsive or compulsive aspect for some in engaging in sexual activity that is problematic for some people. Sexual behavior can be compulsive, similar to symptoms of obsessive-compulsive disorder, where someone has a driving “need” to engage in sexual behavior. Some people have experienced a loss of control with their sexual activity similar to a binge-eating episode. Carnes (1983) and others (Carnes & Love, 2017) pointed out the similarities of how people are addicted to sex as other people are addicted to substances or other

behavioral processes (e.g., gambling, gaming). They highlight parallels of tolerance, cravings, withdrawal, continued use despite negative consequences, and neurological changes that fit for some people who engage in very frequent sexual activity and for engagement in other substance or process addictions.

In regard to the healthiness of very frequent engagement in sexual activity, a broader assessment is needed to ascertain the impact on an individual. There is no clear level of sexual engagement that is healthy; a look at the impetus and consequences for engaging in solo and partnered sexual behavior would help provide insight into how healthy or unhealthy it is for the individual.

Resources:

Sex Help: <https://www.sexhelp.com/am-i-a-sex-addict/>

Sex Addicts Anonymous: <https://saa-recovery.org>

Society for the Advancement of Sexual Health: <https://www.sash.net>

ASSESSMENT STRATEGIES

There are several different instruments that professional counselors can use to more objectively assess whether clients' sexual practices fall out of the range of healthy sexual behavior for adults.

Garos Sexual Behavior Inventory (GSBI)

The GSBI (Garos, 2009) is a 70-item instrument that assesses sexual difficulties and behaviors across four main domains: Discordance, Permissiveness, Sexual Obsession, and Sexual Stimulation. The GSBI also includes masking scales and an Inconsistent Responding Index to account for defensive or random response patterns. The GSBI is useful and versatile across clinical contexts. Although mostly used in the treatment of sexual trauma, sexual addiction, paraphilias, and sex offenders, the GSBI can be used in couples counseling to assess for varying values and comfort levels. The internal reliability coefficients for the GSBI subscales and masking scales scores ranged from .67 to .82 across two studies of approximately 1,500 participants. Test-retest reliability ranged from .62 to .84 for the subscale scores. The GSBI demonstrated convergent and discriminant validity, in addition to predictive validity for identifying sex offenders. Anyone with a master's degree in counseling can purchase and administer the GSBI.

Assessing Healthy Sexual Practices and Sexual Risk-Taking Behavior

Many of the generalized inventories to assess for healthy sexual or sexual risk-taking behavior have been developed for use with adolescents or college-aged young adults. Other than the GSBI, the following two instruments may be useful in clinical practice. Both instruments demonstrated adequate psychometric properties in initial studies, but have primarily been used in research. Thus, the authors suggest professional counselors use assessments to identify potential problem areas and open up conversation about clients' sexual behavior during the interviewing process, and not as diagnostic measures in counseling. Both instruments are published in the *Handbook of Sexuality-Related Measures* (Fisher, Davis, Yarber, & Davis, 2011). Master's level counselors can administer both assessments.

Cognitive and Behavioral Outcomes of Sexual Behavior Scale (CBOSBS). Using SASH's identified outcomes of sexually compulsive behavior, the CBOSBS (McBride, Reece, & Sanders, 2011) is a 36-item measure that assesses social, emotional, physical, legal, financial/ occupational, and spiritual consequences resulting from sexual activities. Professional counselors can use the CBOSBS to assess for individual distress related to sexual behavior (e.g., "I felt guilty."), and if an individual's sexual behavior is potentially causing problems or injuries to others (e.g., "I caused pain, injury, or other physical problems for a sex partner."), thus violating the guidelines for ethical sexual behavior. The CBOSBS has adequate reliability for the cognitive ($\alpha = .89$) and behavioral ($\alpha = .75$) scales. Additionally, construct validity was demonstrated with a six-factor solution accounting for 75% of the variance, aligning with SASH's six outcomes of sexually compulsive behavior upon which the scale was developed. Additional testing is needed for test-retest reliability and other types of validity,

Sexual Health Practices Self-Efficacy Scale (SHPSES). Developed from the guidelines for healthy sexual behavior from SIECUS, the SHPSES (Koch, Colaco, & Porter, 2011) measures individuals' confidence in engaging in healthy sexual practices in a 20-item assessment. In addition to assessing for confidence in using safe-sex practices, the SHPSES includes items that assess for self-efficacy beliefs in regard to decision-making ability, respect for varying sexual orientation (e.g., "Accepting diversity in sexual orientation,"), practices to reverse sex-negativity (e.g., "eliminating sexual double standards [based on gender] in your life."), and relationship fulfillment. In a study of 1,200 undergraduate students, overall internal consistency for the SHPSES was .89, and estimates for the subscale scores ranged from .71 to .82. Researchers have demonstrated construct validity for the SHPSES, discriminant validity in differentiating undergraduate students who have taken sexuality education courses in college from those who have not, and convergent validity with safer-sex behavioral intentions and practices.

Instruments for Specific Disorders

Sexual Addiction Screening Test – Revised (SAST-R). To assess for problematic frequency of sexual behavior (i.e., hypersexuality), the SAST-R (Carnes, Green, & Carnes, 2010) is a 45-item scale that measures four components of sexual addiction: preoccupation, loss of control, affective disturbance, and relationship disturbance. The SAST-R was designed to be clinically viable across gender and sexual orientation, and also includes an addictive Internet use subscale. Internal consistency estimates for the SAST-R scores ranged from .82 to .89 in samples of heterosexual men, heterosexual women, and gay men. The SAST-R has demonstrated an ability to discriminate sexually addictive behavior, with scores above six (6) indicating the likelihood of sex addiction for respondents. The SAST-R can be taken by anyone online to assess for risk of sex addiction; results should be reviewed with a trained counselor, preferably by a Certified Sex Addiction Therapist (CSAT), for diagnosis and treatment.

Paraphilias. The most established instruments to assess for paraphilias are the Multiphasic Sex Inventory-II (MSI-II) and Abel Assessment for Sexual Interest-3 (AASI-3), typically used in forensic settings to identify sex offenders and measure problematic sexual behaviors of sex offenders, most often those who abuse children.

Resources:

Free online version of the SAST: www.recoveryzone.com

Handbook of Sexuality Related Measures: <https://www.crcpress.com/Handbook-of-Sexuality-Related-Measures/Fisher-Davis-Yarber/p/book/9780415801751>

The GSBI is available for purchase on WPS: <https://www.wpspublish.com/store/p/2795/gsbi-garos-sexual-behavior-inventory>

MSI-II: <https://www.nicholsandmolinder.com/index.php>

AASI-3: <https://abelscreening.com>

INTERVENTION STRATEGIES

Intervention strategies to move toward healthy sexuality vary greatly based on the presenting concerns and the client's context. This section will give an overview of several approaches/ interventions that can be beneficial in promoting and facilitating greater sexual health and wellness.

Client Education

Often, client education of various aspects of sexual health is beneficial. Many people experience sex and sexuality as a taboo topic in American culture and do not openly talk about it, even when they are actively curious or concerned about sexual issues. Topics such as basic sex education, issues related to sexually transmitted infections, general communication skills (including assertiveness training), and healthy relationship education can be beneficial for clients depending on their needs in counseling.

Resources:

Center for Positive Sexuality: <https://positivesexuality.org/resources/>

Island Sexual Health: <https://www.islandsexualhealth.org/sexual-identity/healthy-sexuality/>

American Sexual Health Association: <http://www.ashasexualhealth.org/sexual-health/>

Cognitive Behavioral Therapy

Clients thoughts and beliefs can greatly affect sexual health, and cognitive-behavioral therapy (CBT) was shown effective when working with problematic paraphilias (Kaplan & Kreuger, 2012), sexual compulsions/sex addiction/hypersexuality (Crosby, 2011; Halberg, Kaldo, Arver, Dhejne, & berg, 2017; Young, 2013), sexual trauma (Cohen, Deblinger, Mannarino, & Steer, 2004; McDonagh et al., 2005), and some sexual dysfunctions (McCabe, 2001). These researchers highlighted the role of thoughts and beliefs in sexual issues, and the major treatment goals center on working to change thoughts and beliefs to facilitate affective, behavioral, and interpersonal outcomes. Both group and individual counseling CBT approaches showed promise helping clients improve their sexual health.

Resources:

Kaplan & Kreuger's (2012) overview of CBT treatment:

<https://pdfs.semanticscholar.org/4c5d/54e5cfd47606644df3a0a9aa47be857e8ac7.pdf>

Integrative and Systemic Approaches

While a significant number of interventions for sexual issues use individual or group counseling, more systemic and integrative approaches also can be used. Couples counseling has been recommended for a range of sexual issues including relational distress or trauma (Johnson, Hunsley, Greenberg, & Schindler, 2006), low sexual desire, and reducing risk of sexually-transmitted infections (LaCroix, Pellowshio, Lennon, & Johnson, 2013). Couples counseling can immediately address and potentially resolve relational issues that impact clients' sexuality and can provide a different mechanism for helping clients to achieve sexual goals. Sexual communication has often been cited as an important variable for sexual satisfaction (Byers, 2011; Montesi et al., 2013), and couples counseling can be an important and powerful approach to help clients improve their sexual communication. Behavioral interventions also are commonly recommended as treatment for sexual dysfunctions and sexual relational dynamics (Sugrue, 2007). These can be used in individual counseling sessions or can be combined into couples counseling and integrated with more relational approaches (including emotion-focused therapy; Johnson et al., 2006). By bringing the sexual partner into sessions, counseling can create positive changes for the client.

Group interventions, including 12-step groups, other support groups, and psychoeducation groups, were also beneficial interventions for sexual issues (Carnes, 2000; Efrati & Gola, 2018; Sugrue, 2007). Clients coming in for issues related to infertility, compulsive sexual compulsivity/sex addiction/hypersexuality, sexual dysfunctions (medically or otherwise related), and sexual education may benefit from group treatment.

Treatment for Specific Atypical Sexual Behaviors

Treatment for problematic paraphilias. Treatment for problematic paraphilias usually focuses on four aspects: a) decreasing the intensity and frequency of sexual desires and arousal; b) increasing awareness; c) limiting exposure to sexually arousing stimuli; and d) treating comorbid disorders (Kaplan & Krueger, 2012; Sandat, 2014). Typically, this is done by using a combination of psychopharmacological and CBT treatments (Garcia & Thibault, 2011; Kaplan & Krueger, 2012; Thibault, 2012). CBT for paraphilic behaviors can be beneficial in examining and changing irrational beliefs, social and assertiveness training, sexual education, and trauma (Kaplan & Krueger, 2012). Medications for paraphilias include Gonadotrophin-releasing analogues (GnRH), selective serotonin reuptake inhibitors (SSRIs), and steroidal antiandrogens (Garcia & Thibault, 2011; Thibault, 2012).

Treatment for people who committed sexual crimes. Treatment for people who have committed sexual crimes is similar to treatment for problematic paraphilias, as some paraphilic disorders include symptoms that are criminal behaviors. Therefore, the treatments of CBT and psychopharmacology are commonly used with people who have committed sexual crimes. Often counselors working with clients convicted of sexual crimes provide reports of the clients' progress to the court/probation officers and need to be competent at navigating the relevant ethical and legal implications.

Treatment for compulsive sexual behaviors and hypersexuality. Since there is still some controversy and ongoing debate around sexual compulsions/sexual addiction/ hypersexuality, there are not clear data on which are the most effective current treatments (Efrati & Gola, 2018); however, there are some promising approaches in working with clients with these concerns. Notably, CBT (Crosby, 2011; Halberg et al., 2017; Young, 2013), mindfulness (Reid, Bramen, Anderson, & Cohen, 2014), 12 step groups (i.e., Sex Addicts Anonymous or Sex and Love Addicts Anonymous; Carnes, 2000), and pharmacological treatment (Efrati & Gola, 2018). There is a range of medications used based on the symptoms that a client is experiencing. Couples therapy and treatment of comorbid diagnoses also have been recommended for clients with sexual compulsions/sexual addiction/hypersexuality (Carnes, 2000; Murray et al., 2017). The goals of treatment can vary from abstinence (having no sexual behaviors outside of sexual intercourse) to addressing the harmful consequences of the sexual compulsions/addiction (Efrati & Gola, 2018). Several researchers (Carnes, 2000; Carnes, Murray, & Charpentier, 2005; Goodman, 2001) advocate for a multi-phase approach to treating sexual compulsions/sexual addiction/hypersexuality that lasts for more than one year.

Resources:

Bourget & Bradford's (2008) review of treatment approaches for people convicted of sexual crimes: <https://pdfs.semanticscholar.org/fc13/7f2f44c2bc505ce3567c9b7c54953d75050c.pdf>
Kaplan & Krueger's (2010) review of treatment for sexual compulsions, sexual addiction, and hypersexuality: <https://www.jstor.org/stable/pdf/25676449.pdf>

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