Journal of Psychology and Christianity
2007, Vol. 26, No. 1, 3-13

ISSN 0733-4273

Sexual Addiction and Christian College Men: Conceptual, Assessment, and Treatment Challenges

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The sexual addiction concept, which conventionally assumes partnered sex, creates a dilemma when young, unmarried Christian men, such as those seen at Christian college counseling centers, eschew partnered sex because of religious pressures but are silently addicted to solo sex behavior, e.g., masturbation and using pornography. We argue that these men are sexually addicted when they depend on solo sex behaviors to regulate their emotional state. The unique characteristics of this group create challenges in assessing for sexual addiction using the standard quantitative screening instruments, the limitations of which are discussed followed by suggestions for contextualizing assessment and treatment.

Christians and the controversy of sexual addiction

An increasing number of clinicians and researchers recognize the presence of a syndrome marked by compulsive and addictive sexual behavior that affects a component of the population. Although the precise designation of such a condition is the subject of considerable disagreement and debate (Barth & Kinder, 1987; Goodman, 2001; Kafka, 2001; Shaffer, 1994), many clinicians are in one accord that the condition warrants treatment due to the distress and functional impairment that it causes. Nevertheless, the existence of such a syndrome of driven sexual behavior (which we hereon refer to as "sexual addiction," its most common designation in the literature) is by no means universally accepted among clinicians and researchers. While we acknowledge that there are many socio-cultural and nosological disputes around sexual addiction, these controversies are beyond the scope of this article. For the purpose of our present discussion, we simply state our belief that sexual addiction is a disorder that exists but suffers from a lack of diagnostic clarity.

One ramification of the conceptual vagueness surrounding sexual addiction is the mistaken belief among some evangelicals that all sexual behaviors of a driven and unwanted nature represent sexual addictions that require treatment. The somewhat uncritical use of addictions nomenclature to describe problematic hypersexuality is perhaps reflected in an article in *Today's Christian Woman* (Richards, 2003), which described the female analog of sex addiction as a syndrome of internet-related activities organized around romantic fantasy. One thing is clear whether one agrees or disagrees with this author's assertions: the label "addiction" lends itself to particular beliefs about "addicts" and how they should be helped. These beliefs are rooted in an ideology that has been shaped to a large extent by the disease model of alcoholism and the Twelve Step model of recovery, but increasingly they are used to conceptualize excessive behaviors that are morally problematic.

Questioning sex addiction among Christian college men

One group of people for whom the term "sexual addiction" is problematic is male students at evangelical Christian colleges who are distressed by masturbation and pornography use.[1] The problems of these young men reflect the issues faced by the broader group of unmarried evangelical persons who are unsure about the place of sexuality in their lives, and experience tension and discomfort with their sexual feelings because their value system and religious beliefs preclude engagement in partnered sex. As counselors at the Wheaton College Counseling Center, we (Ferrell and Kwee) dealt significantly with issues of male sexuality, including running therapy groups for men distressed by masturbation and pornography use and wishing to develop a healthy understanding of sexuality. While we believe that some of our clients (a minority) struggle with an actual addiction, we are surprised by the number

An earlier version of this article was presented on September 24, 2005, at the National Conference of the Society for the Advancement of Sexual Health. Please address any correspondence to Alex Kwee at akwee@meierclinics.com or by contacting Meier Clinics Foundation at (630) 653-1717.

of clients who are disposed to believe that their developmentally normative struggles with masturbation are of an addictive nature. Approximately 60% of male students who indicated that they were consulting a counselor because of sexual concerns believed or suspected that they struggled with sexual addiction, whether or not they were actually assessed to have an addiction. We speculate that one socio-cultural explanation for this may be the explosion of evangelical Christian literature on "sexual purity" that has occurred in parallel to the popularizing of the sexual addiction concept. With "sexual purity" a virtual catchphrase among abstinence-minded Christians and the sexual addiction concept holding a certain prominence in the pop psychology marketplace, is it surprising that more and more Christians are wondering if their unwanted sexual appetites are the result of an addiction? Interestingly, there may be an analog to this in alcoholism. Peele (2000) reports:

> At the time between the late 1960s and early 1980s when the concept of alcoholism became a heavily marketed cultural icon, drinking did not increase in the U.S. Nonetheless, [National Institute of Alcohol Abuse and Alcoholism] surveys revealed a sharp and significant upturn in those reporting symptoms of alcohol dependence (although not of ordinary drinking problems)—a rise that has not reversed itself since. Both in this historical phenomenon and [some epidemiological research findings], we see that thinking about addiction and about one's behavior precedes and determines the addictive experience. (p. 603)

As counselors we sometimes see, played out on an individual level, how one's thinking about sexual behavior shapes the addictive experience. One particular discussion during a group meeting helped one of us (Kwee) to understand a line of reasoning some male students use for justifying that they have a sexual addiction. At this meeting it had been suggested to the clients that because masturbation was a developmentally normative behavior for their age group, perhaps their distress over their inability to "quit" masturbation was unwarranted and even counterproductive. This suggestion made the group members noticeably ill-at-ease, and several of the men then voiced the belief that because it was impossible for them to conceive of "healthy" masturbation under any circumstances, they felt that it was prudent to err on the side of believing they had a sexual addiction, since this would warrant their efforts to completely cease masturbatory behavior.

Beyond our feeling that such beliefs are simply counterproductive to spiritual growth and the development of a healthy personality free from false guilt, the contradiction of unmarried young men who confess to a sexual addiction despite not engaging in partnered sexual activity poses a dilemma both conceptually and clinically. At the same time, we estimate that a minority (around 5%) of all male clients worked with over a two year period display clear addictive patterns based on their compulsive dependence on masturbation and pornography to alleviate internal distress. Our observations are in line with models of sexual addiction that propose pervasive emotional dysregulation as the underlying mechanism of the addiction process (Goodman, 1993; Schwartz & Southern, 1999). Given that clients' evaluation of their masturbation "problem" is highly subjective, often colored by personal religious values and other idiopathic variables, how does the clinician know whether he or she is dealing with a case of unnecessary and excessive guilt over developmentally normative sexual feelings and behavior, a spiritual problem, or the beginnings of a true sexual addiction?

We will preface our discussion of this question with a theological presupposition. As Christians, we hold that all psychological problems are rooted in our sinful and spiritually fallen condition.[2] A traditional Christian anthropological view of the person holds that because of the unitary character of our constituent elements, it is unwise to partition problems into the "spiritual" and the "psychological" (Jones, 2001). We pose the above question only as an artificial device to help counselors to clarify the *focus* of their intervention. The possible interventions for a young man struggling in his sexuality range from professional counseling to pastoral and lay counseling to men's groups and peer accountability relationships. Mirroring these diverse options are a range of bibliotherapies for men that include traditional recovery literature (e.g., Carnes, 1991), explicitly Christian recovery literature (e.g., Laaser, 1996), as well as biblically-based help for a non-addicted population struggling with sexual temptation (e.g., Arterburn, Stoeker, & Yorkey, 2002). Such a

range of intervention options calls for a careful assessment of the nature and severity of a client's struggle to determine the form of treatment that will avail the most to him.

We argue that because sexual struggles are generally par for young men's developmental trajectories, we should downplay the role of professional counseling when our clients present with sexual struggles that are not part of any discernable clinical pathology. At WCCC, we generally encourage non-addicted clients who are otherwise troubled about their sexuality to locate their struggle within a broader context of spiritual growth. We especially encourage these clients to seek out different levels of spiritual accountability (e.g., a pastor, a mentor, or a men's prayer fellowship), and to use counseling as an adjunctive and not the primary means to resolve problems in their sexuality. The sexually addicted client does, however, warrant intensive clinical attention, which summons a host of assessment and therapeutic considerations and challenges that we will address later in this article.

The question of masturbation

It is necessary now to turn our attention to the dilemma of masturbation since this is a truly vexing moral and behavioral problem for many Christians who are unmarried, which includes the vast majority of male students who seek our help in dealing with sexual compulsivity. As Sanford (1994) has noted, much needless distress arises out of the silence, confusion, and misinformation that attend the issue of masturbation. Many Christian college men who are distressed by masturbation attempt to resolve their guilt by intensifying their efforts to completely stop masturbation, developing what Jones and Jones (1993) have called a "compulsion to stop" (p. 192) that becomes just as driven as the urge to masturbate, leading to a vicious positive feedback cycle that reinforces rather than eradicates masturbation.

The growing popular awareness of sexual addiction in combination with the evangelical emphasis on sexual purity may have created the latest self-defeating myth about masturbation: that the person who masturbates or otherwise struggles with unwanted sexual feelings and behaviors somehow has a sexual addiction. Unfortunately, this new myth is not as readily debunked as the other patently false consequences accompanying masturbation (blindness, pimples, stunted growth, etc.), so it behooves us to thoughtfully examine the facts about masturbation that can be gleaned from the best research.

Study after study indicates masturbation to be a common though not universal behavior among males. In the most extensive study of male sexual behavior ever conducted, Kinsey, Pomeroy, and Martin (1948) found that prior to marriage, 95% of adult males have masturbated to orgasm. Although studies since then have generally corroborated this statistic, Jones and Jones (1993) caution that the failure to distinguish between one-time occurrences and regular occurrences in sexuality research is likely to have created the impression that masturbation is more common than it actually is. A study of college students' pre-coital sexual behavior found that while masturbation was common among male students, with 85% of the male sample responding that they had masturbated at least once, the actual percentage of the sample that rated the frequency of masturbation as either moderate ("occasionally") or high ("frequently" or "very frequently") was 71% (Schwartz, 1999). Comparable findings are reported by Elliot and Brantley (1997), whose survey of sexual practices among college students found that 88% of male students acknowledged any masturbatory activity, and that 64% of male students engaged in masturbation at least once a week. Thus it appears that while masturbation is a common behavior among college males, it is neither as prevalent nor as frequent as implied by large scale sexuality studies. Nevertheless, we may reasonably conclude from the body of evidence that masturbation is a very common behavior among unmarried males in general, and that it is a developmentally normative behavior that we can expect most college men to have engaged in at some point. Given that the best estimates place the prevalence of sexual addiction in the general population at 3-6% (Carnes, 1991; Coleman, Miner, Ohlerking, & Raymond, 2001), this would suggest that in the vast majority of cases, masturbation is not symptomatic of a sexual addiction, and it does not lead to the development of a sexual addiction.

Silence and misconceptions about masturbation often conspire to create much unwarranted guilt and distress among young men who sincerely desire to be faithful to the requirements of biblical sexual morality. While counselors can assist in debunking myths and allaying unnecessary fears, they can also encourage clients to seek out their own well-informed answers about the place of masturbation within a framework of

traditional Christian sexual ethics. It seems to us that the most reasonable and balanced Christian views about masturbation (e.g., Butman, 1999; Jones & Jones, 1993; Sanford, 1994; Smedes, 1994) are less prohibitive than most clients realize, and overreactions of guilt are thus likely to be avoided as clients become acquainted with these views. These writers generally hold the view that there is no need to exacerbate guilt over a developmentally normative issue on which the Bible is silent. Moreover, their views place masturbation within a bio-psycho-spiritual developmental context of "the person's drive toward intimate communion, where one has the other person's interests and fulfillment in mind" (Butman, 1999, p. 727), that is, masturbation is viewed as a developmental issue that cannot be separated from the Bible's particular moral vision of right relationships between men and women. This vision lies within the broader biblical ideal of holy community "that has as its final telos right relationships both with God and among persons" (Sanford, 1994, p. 21). Therefore masturbation, while indeed a behavior that has great potential to impede the realization of right relationships between the sexes and between humans and God, does have a place in human development that, in a limited sense, promotes the ultimate purpose of intimate communion between a man and a woman. This is stated cogently by Smedes (1994), who suggests that masturbation is a temporary solution to a normal developmental dilemma that occurs when biological development is out of step with the social and psychological realities of young people – realities that prevent them from achieving sexual intimacy with another person. As a solution, then, masturbation is temporary and not meant to be personally sufficient; rather, the after-feelings of lack and dissatisfaction ought to drive one to pursue the full sufficiency that is found within the intimacy of a wholesome heterosexual union (Smedes, 1994).

Nevertheless, in normalizing masturbation to some extent, we do not mean to ignore or minimize the very real moral problems with the thoughts and/or behaviors that are often attendant to masturbation. Most moral objections to masturbation point to the connection between masturbation and lust and fantasy. In distinguishing between lust and fantasy, the point is generally made that lust is always sinful—often with particular reference to Jesus' condemnation of lust in Matthew 5:27-28—and fantasy can be either healthy or unhealthy (Balswick & Balswick, 1999, p. 246-248; Sanford, 1994). Since fantasy appears to be the norm during masturbation (according to research cited by Sanford, 1994), close attention needs to be paid to whether one's fantasies during masturbation involve lust or appropriate fantasies (e.g., desires involving one's future spouse), a difference that Balswick and Balswick (1999, pp. 246-248) suggests that the person who is masturbating is able to discern. However, we would argue that for many young men the difference is not at all clear, and the person who is masturbating may not be the best judge of whether his fantasies are of a healthy or unhealthy nature. Clinical experience suggests that for the vast majority of college men who struggle with compulsive masturbation, pornography is inevitably involved to some extent. This agrees with Carnes' (1991) finding that for 90% of male sex addicts surveyed, pornography is significantly involved in their addiction. Quite apart from the fact that pornography fuels lust and unhealthy fantasy, it also distorts men's ideas about "normal" sexuality and their physical ideals of women and intimate relationships. When pornography is used repeatedly as stimuli in masturbation (whether directly or indirectly, as when a man calls to mind sex acts he has seen in a magazine while masturbating), fantasy and pornography become so intertwined that for the young man struggling with compulsive masturbation, the difference between appropriate desire and lust-fuelled fantasy is far from clear. In a world where the norms of sexuality are distorted by a highly sexualized popular culture and easy access to pornography, the difference between appropriate and inappropriate masturbation is often vague. The clinician is thus faced with the challenge of normalizing masturbation without leading the client down the proverbial "slippery slope," along which masturbation escalates towards unhealthy excess and compulsivity.

When masturbation and pornography are gateways to sexual addiction

Given that most clients who are troubled by masturbation and pornography use are not at risk for developing a sexual addiction, what type of client, then, is at risk for developing a sexual addiction? This question is of course underpinned by two more fundamental questions that we first need to address: (1) What is addiction? (2) Does sexual addiction exist? We agree with Goodman

(1992), who states, "The concept of addiction suffers from a lack of a generally recognized definition that is clear and meaningful" (p. 304). Compounding the matter is that the taxonomy of addiction in the current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*) (APA, 2000) is substance—as opposed to process or behavior—specific, and it tends to identify addiction by its physiological, personal, and social consequences rather than by the generally recognized emotional dynamics that underlie compulsive behaviors. The nosology of alcohol addiction, for instance, is based on the consequences of excessive alcohol use (i.e., intoxication, dependence, withdrawal, abuse) and not on the emotional and behavioral dynamics that underlie problem drinking (APA, 2000, pp. 212-217). Where they are recognized in the *DSM-IV-TR*, the behavioral addictions (e.g., pathological gambling, the eating disorders, and the paraphilias) are classed under separate and unrelated nosologies. Neither the concepts of sexual compulsivity nor sexual dependence (the underpinnings of sexual addiction) are found in the *DSM-IV-TR*, although an example listed under the category of Sexual Disorder Not Otherwise Specified alludes vaguely to compulsive sexual behavior: "Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used" (APA, 2000, p. 582).

One scientifically and clinically useful formulation of addiction has been provided by Brown (1993) and modified by Griffiths (1996): A behavior (whether drug taking, smoking, or sex) is an addiction if it includes the core components of salience (i.e., the activity in question dominates thinking, feeling, and behavior), mood modification, tolerance, withdrawal, conflict (including intrapsychic, interpersonal, and role conflict), and relapse. An alternate formulation by Goodman (1992) views addiction as behavior marked by the presence of compulsivity, dependency, repetition, and continuation in spite of significant harmful consequences. According to this formulation, compulsive behavior is motivated by an attempt to avoid or suppress an aversive internal state, while dependency is seen as the culmination of using the behavior habitually for gratifying basic or derived needs, and for achieving a pleasurable internal state. Addiction is thus:

> A disorder in which a behavior that can function both to produce pleasure and to provide escape from internal discomfort is employed in a pattern characterized by (1) recurrent failure to control the behavior, and (2) continuation of the behavior despite significant harmful consequences. (Goodman, 1992, p. 304)

A significant advantage of Goodman's definition is that it is oriented to the familiar diagnostic criteria as well as being process-oriented, that is, it recognizes the salient features of addiction along with the fact that addiction consists in compulsive behavioral patterns developing out of emotional dysregulation. Goodman (1993) defined "addictive process" as "the compulsive dependence on external actions as a means of regulating one's internal states (feelings and sense of self)" (p. 233). This accords with clinical observations that sex addicts "ritualize" sexual activity according to the flawed and circular emotional logic of the addiction cycle (Laaser, 1996; Laaser & Machen, 1996), reflecting the concretization of sexual dependence and compulsivity by the underlying addiction process.

The focus on emotionally-driven process implies that addiction develops out of an interaction of intrinsic and contextual factors. However the etiological model is conceived, whether bio-psycho-spiritual (May, 1988), or bio-developmental with the relative emphasis on neurological factors (Milkman & Sunderwirth, 1987) or on developmental factors (Schwartz & Southern, 1999), the multicausality of addiction is well established in the literature and broadly accepted by professionals. Few professionals would dispute that addiction is maintained by learned behaviors that help the addict to deal with his or her dysregulated emotions. Thus the addiction process functions both to suppress overwhelming emotions and (less obviously) to release numbed emotions, which helps us to understand why clients who struggle with compulsive pornography use and masturbation sometimes say to us, "I understand why I do it when I'm (stressed/anxious/depressed), but I don't understand why I do it even when I'm bored." Schwartz and Southern (1999) state aptly the culmination of maintaining, via the addiction process, learned coping behaviors: "Eventually the individual may feel pleasure and safety only when acting out. The individual has bonded with the object of addiction as a means of internal regulating and calming" (p. 171).

Does sexual addiction exist? We will not attempt to answer this question in any manner that justifies its importance except to say that there is no lack of clinical evidence that for some individuals, sexual activity is clearly excessive, unmanageable, and personally distressing for reasons other than socially or culturally enforced "guilt" for deviating from normative sexual behavior. Libertarians who argue that the sexual addiction concept is a moral policing device to punish people who deviate from sexual norms have no good answer when confronted by real life examples of individuals whose lives are destroyed because of loss of control over their sexual behavior. While we maintain that the concept of sexual addiction is frequently misapplied and even abused, we believe that the construct is clinically useful for understanding clearly excessive, unmanageable, and distressing patterns of sexual behavior in some people.

Assessment of sexual addiction

Recognized as "building block behaviors" in the etiology of sexual addiction, compulsive masturbation, pornography use, and sexual fantasizing can compound into even more serious behaviors that have potentially destructive psychological, relational, and even health consequences (Carnes, 1991; Carnes, 2001; Laaser, 1996; Laaser & Machen, 1996). These behaviors are particularly destructive because they impair the formation of healthy social and intimate relationships, a key developmental task for the life cycle stage of young adulthood. Because sexual addiction directly interferes with the formation of intimate relationships and the subsequent developmental challenges of marriage and family life, it is crucial to assess the problem and intervene as early as possible.

How can clinicians assess for sexual addiction in clients, bearing in mind that most college men will not demonstrate the full gamut of addiction features? We believe that it is crucial to look at the client's relationship to his sexual behavior and the emotional meaning that the behavior holds for him. Conceptually we find Carnes' (2001) formulation of addiction as a pathological relationship with a mood altering experience to be a useful place to begin thinking about the meaning of sexual activity for our clients. Nakken (1988) employs a more existential formulation of addiction that retains the essential element of a pathological relationship to something that is used to alter mood. He states, "[Addiction involves] the out-of-control and aimless searching for wholeness, happiness, and peace through a relationship with an object or event. No matter what the addiction is, every addict engages in a relationship with an object or event in order to produce a desired mood change, state of intoxication, or trance state" (Nakken, 1988, p. 2). Both of these formulations, while suffering from a lack of scientific precision, convey the essential notion of the addict's pathological relationship to *something* that is used to regulate his or her internal state. We believe that, in contrast to the client whose masturbation pattern is within the developmentally normative range, the addicted client uses masturbation (usually with pornography) regularly as part of his repertoire of behaviors to self-soothe or regulate his internal state. It is precisely such a pattern of sexual activity (i.e., to numb distressing emotions) that is at risk of becoming addictive by the bio-psychological mechanisms that have been described by Goodman (1993), Schwartz and Southern (1999), and more generally (in the case of compulsive behaviors) by Milkman and Sunderwirth (1987). As such, a consideration of the emotional meanings of the sexual behavior and the function it serves for the client ought to be central to any assessment of sexual addiction.

The limitations of formal sexual addiction assessment instruments

A number of attempts have been made to develop scales to identify individuals who are sexually addicted (e.g., Carnes, 1989; Coleman et al., 2001; Kalichman & Rompa, 1995; Kalichman & Rompa, 2001). While useful, these inventories lack applicability in a number of ways for Christian college men— and unmarried evangelical Christians in general —who struggle with sexual compulsivity. The terminology used in these scales is often vague and therefore open to a number of subjective interpretations. At the same time, the use of targeted questions reduces the generalizability of these inventories across sexually addicted subpopulations. Specific to religiously-oriented individuals, these inventories fail to take into account the demand characteristics of Christians who deal with sexual addiction. Also, as these scales assume some level of engagement in partnered sexual activity, they would likely fail to identify addicted individuals who engage only in solo sexual behaviors—the very behaviors most present among Christian

college men and other evangelical young adults who are unmarried.

One sexual addiction screening instrument, the Sexual Addiction Screening Test (SAST) (Carnes, 1989) is widely known, readily available, and frequently used as a quick screening instrument. The SAST is a 25-item dichotomous ("Yes/No") questionnaire that attempts to gather data identifying the extent of sexual behavior, the presence of obsessive and unmanageable sexual feelings and behavior (and accompanying shame and depression), and the presence of catalytic events and systemic variables that precipitate and sustain addictive behavior. Unfortunately, the SAST is undermined by inadequate validation studies and, specific to Christian college men, lacks relevance for certain subgroups of religiously-oriented individuals. For instance, the demand characteristics of some of our especially guilt-prone clients who are sexually chaste but troubled by masturbation may cause them to endorse several items such as Item 5, "Do you feel that your sexual behavior is not normal?" or Item 8, "Do you feel bad about your sexual behavior?" Moreover, the failure of the SAST to define key terms like "sex" and "sexual behavior," and to distinguish between partnered and solo sexual activity, reduces further the validity of this inventory. For example, a sexually chaste client who struggles with compulsive masturbation and pornography use may interpret the items to reference partnered sexual activity, fail to endorse many items, and thus fall under the diagnostic radar of the SAST. On the other hand, those with a broad enough interpretation of "sex" and a strong enough guilt reaction to the normal dimensions of human sexuality may endorse a far greater number of items and be misdiagnosed with sexual addiction. A final serious weakness of the SAST is that by restricting responding to "yes" or "no," the instrument yields no information about frequency or strength of endorsement.[3]

Another diagnostic tool, the Compulsive Sexual Behavior Inventory (CSBI) (Coleman et al., 2001), was normed on groups with severe sexual addiction: Non-paraphilic compulsives, pedophiles, and sexual offenders. Yet another instrument, the Sexual Compulsivity Scale (Kalichman & Rompa, 1995, 2001) was normed on gay men and HIV-positive individuals. Although psychometric studies support their usefulness, as with the SAST, these scales lack validity for individuals whose religious orientation influences their view of sexuality and/or who do not engage in partnered sex. It appears that the use of these instruments may not be generalized beyond the particular clinical subpopulations on which they were normed. Not only did these norming samples possess a more extreme form of sexual addiction, in the case of the CSBI, the addiction is also associated with the type of severe pathogenesis that is uncommon among non-offending sex addicts.

We are encouraged by the ongoing development of a promising new instrument, the Hypersexual Impulsivity Behavior Inventory (Reid & Garos, 2006). The 80 items of the HIBI, which are answered on a 5-point scale from *Never* to *Very Often*, are generated from an extensive literature review and have been evaluated by several prominent researchers for face validity. Currently the instrument is being tested in clinics in the U.S., Canada, and Europe. The HIBI improves on the other sexual addiction assessments in at least three respects. First, the items are prefaced by instructions that eliminate ambiguity around the term "sex" by defining it precisely as "any activity or behavior that stimulates or arouses a person with intent to produce orgasm and sexual pleasure," a definition which includes, along with intercourse, non-coital activity such as using pornography and self-masturbation (Reid & Garos, 2006). Second, the HIBI appears to be psychometrically superior in terms of excellent content validity, the rigor of its development, and the breadth and size of its norms (which encompasses outpatient, inpatient, residential, college, gay, and religious samples). Third, the HIBI appears to have good clinical utility for assessing a religious population. At this preliminary stage, factor analysis evaluating construct validity of the HIBI has yielded four factors which have been named Consequences, Coping, Congruence, and Control to describe four hypothesized areas of concern. The factor of Congruence describes sexual addiction as a postulated function of degree of incongruence between the patient's sexual behavior, and his or her personal beliefs and values (Reid & Garos, 2006). This suggests that the HIBI has potential to discriminate the degree to which endorsement of sexual addiction may be rooted in subjective beliefs about sex which are filtered through a religious value system.

Notwithstanding the clinical potential of the HIBI, we believe that quantitative assessments do not replace but should be used in combination with a qualitative, interview-based assessment of

sexual addiction, particularly for unique populations. We believe that a well-designed interview would yield superior clinical data by allowing the clinician to flesh out the specific nature, degree, and emotional function of sexual behavior, along with the existence of any comorbid psychological conditions. For young, unmarried evangelicals specifically, an interview would yield richer clinical insights into the complicated interaction of contextual variables—faith, family system, developmental stage, etc.—that mediate the expression of sexual addiction.

Intervention

An optimal treatment strategy for sexual addiction should consist of a combination of individual and group therapy. Group therapy, in particular, is regarded as a cost effective and essential component of treatment, not merely an adjunct modality to individual therapy. According to research summarized by Line and Cooper (2002), this is due to the documented effectiveness of group therapy in treating both nonparaphilic and paraphilic sexual compulsions; in confronting the defenses employed by addicts and helping them to develop more effective coping strategies; in improving functioning within a social unit; in decreasing shame, secrecy, and isolation; and in increasing self-understanding through the development of mutual empathic identification.

Despite the acknowledged effectiveness of group combined with individual treatment, we hold that a treatment program for sexually addicted evangelical college men will not be optimally effective unless the contextual characteristics of this population, which mediates a unique expression of sexual addiction, are recognized by the intervention. Given that sexual addiction is a progressive disorder with varying expressions and levels of severity, treating the male Christian college student who is grappling with addiction looks very different than treating the older married man who frequents prostitutes, the sex offender, the paraphilic compulsive, or the promiscuous gay man. Effective treatment should be attentive to the protective and risk factors inherent to each of the following salient characteristics of Christian college men: (1) nature of sexual behavior and stage of addiction, (2) developmental stage, and (3) Christian beliefs and values. Understanding how these factors apply to the sexual struggles of this client population informs the context in which the treatment of sexual addiction takes place.

Nature of sexual behavior and stage of sexual addiction. At Wheaton College Counseling Center, nearly all the male clients seen for sexual addiction are not sexually active but engage exclusively in the solo behaviors (i.e., masturbation and pornography use).[4] As with the instrument-based assessments we reviewed above, all of the intervention paradigms we are familiar with assume that clients have been or are currently engaged in partnered sexual activity. Because our clients fit the profile of sex addicts but are technically chaste, the common treatment paradigms may lack salience for them. We suggest that interventions for Christian college men should be closely tailored to the limited dimensions of their sexual behavior and recognize that these men deal with addiction despite not engaging in actual intercourse. At the same time, the fact that the sexual behaviors generally have not progressed beyond masturbation and pornography use yields a hopeful prognosis and suggests that an effective intervention should be in part preventative.

Developmental stage. Treatment should be informed by an understanding of the life cycle stage of college-aged men. The challenges of this developmental stage, popularly referred to in Eriksonian terms as "intimacy versus isolation" (Erikson, 1964, pp. 263-265), include a growing interest in and nurturing of intimate relationships with the opposite sex (with a view towards marriage), as well as continued identity formation and individuation from one's family. It is vital for counselors to view treatment within a life cycle perspective because sexual addiction interferes with the development of intimate relationships and the subsequent developmental challenges of marriage and family life.[5]

The fact that the vast majority of college men are unmarried is salient for treatment planning because singleness factors into the addiction of each unmarried client in different ways that can be either positive or negative. We have worked with a number of unmarried clients who were engaged to be married or were otherwise in committed relationships. These clients were highly motivated to seek treatment because they anticipated their sexual addiction becoming a roadblock in their future marriages. On the other hand, we have also worked with clients who perpetuated their addiction in the belief that they had little to lose from their sexual behavior as unattached young men, or because they held the fallacious notion that marriage would resolve

their struggles. The motivation of unmarried men to deal with their sexual behavior obviously varies with their psychological and spiritual maturity level, which determines their ability to anticipate the long-term consequences of their behavior. Regardless of the motivation level, given that there is less at stake for most college men (i.e., no wife, family, or job to lose to their addiction yet), we believe that there is no better time to intervene than when they are in college and counseling at minimal cost is available.

Evangelical beliefs and values. The evangelical faith of our clients is a significant protective factor that should not be overlooked. At WCCC, the men who we treat for problematic sexuality for the most part aspire to lives of sexual integrity in accordance with Christian scripture. Our clients' faith in a loving, all-powerful, and dependable God is central to their recovery and to our intervention with them. Behaviorally speaking, faith also serves as a protective factor because of Christian proscriptions against pre-marital sex and other forms of sexual immorality. However, biblical teaching as well as clear behavioral standards in the college community (couched in the form of "community covenants") that eschew immoral sexual behavior often serve to drive pornography dependence and compulsive masturbation—behaviors that are already shameful enough—even further underground. The combination of addictive sexuality, secretiveness, and shame can lead to a dangerous level of "splitting" and denial among young evangelical men who will not deal with their behavior until the psychological toll becomes too high.

Our clients' struggles in many ways represent the dilemma of being a Christian caught in between an evangelical subculture that constantly espouses the virtue of "sexual purity" (while often leaving the term unhelpfully vague) and a broader secular culture that, in its highly sexualized nature, espouses a far more liberal sexual ethic. In helping our clients, we need to be realistic about and sympathetic to what they are up against in the broader culture. At the same time, we also need to acknowledge that the evangelical subculture is partly responsible for exacerbating the guilt and shame they experience by oversimplifying the nature of sexual struggles and failing to create a safe and non-judgmental atmosphere in which healthy dialogue about sexuality can take place. The consequence is that where our young men and women should be seeking to understand and integrate their sexuality as part of their personhood, too many of them are hanging their heads in shame over their perceived failure to master their sexuality. Even worse, those who struggle with the beginnings of sexual addiction are driven to disavow their struggles out of shame and guilt, which creates the very engine that drives their addiction into unmanageable proportions.

Future Directions for Research

Any clinical intervention should be evaluated for efficacy, and the contextualized treatment for sexual addiction suggested above is no exception. While Christianized interventions for sexual addiction, sex education, or promotion of healthy sexuality have proliferated, including the widely used resource by Laaser and Machen (1996) and the virtual cottage industry of Christian self-help resources for "victory over sexual temptation" targeted to every conceivable demographic (e.g., Arterburn et al., 2002), these tools have not been treated with the critical scrutiny they deserve by Christian mental health professionals, let alone been evaluated for their efficacy and impact on Christian sexual identity formation. We hope that any sex addiction intervention that adopts our suggestions for contextualization will be critically evaluated for its efficacy. We also hope that sexuality research will shed light on the sexual practices and pathologies of Christians. It will be especially useful to have data on the frequencies of various sexual behaviors and the prevalence of sexual disorders, including sexual addiction, for both males and females in the Christian community. Such data will move us beyond anecdotal discussion towards identifying actual needs and at-risk groups, and targeting interventions and preventative programs accordingly.

Conclusion

The conceptual vagueness around sexual addiction creates significant challenges in assessing and treating young, unmarried evangelical men, such as those attending Christian colleges, who struggle with compulsivity in solo sexual behavior and eschew partnered sexual activity because of their religious beliefs. Because addiction is a process rooted in emotional dysregulation, sex addiction is a valid concept when people depend on sexual behavior to regulate their mood state. The conventional thinking is that sex addiction is addiction to partnered sex, but we have argued that chaste individuals may be sexually addicted when they

use masturbation and pornography to cope with negative mood states. Helping Christian young men who are "chaste sex addicts" involves understanding how factors like religious faith and developmental stage delimit sexual choices and influences the manifestation of sexual addiction, which thereby helps clinicians to contextualize the intervention appropriately. Accurately assessing sexual addiction in this (or any other) special population requires taking into account its unique contextual reality, a task for which most quantitative sexual addiction screening measures fall short.

Notes

1. We wish to be clear at the outset that our discussion of sexual addiction is referenced to and limited to the scope of heterosexual males. The question of male homosexuality and sexual addiction is an important one made even more complex by the variables of religious faith and societal homophobia. It is a topic that demands separate attention.

2, We state our position as an epistemological assumption that guides our analysis. We acknowledge that while most Christian readers will be in sympathy with this position, there are some who wrestle with its broader implications when it comes to illness and the myriad other forms of inexplicable suffering in the world.

3. At press time, it is understood that the SAST is being revised by Patrick Carnes, Ph.D., Stephanie Carnes, Ph.D., and Brad Green, Ph.D. It will be interesting to see whether the new instrument addresses these concerns.

4. Obviously this is not representative of all unmarried evangelical males of comparative age because our sample is limited and self-selected in that these clients sought out our counseling services. Our field is in want of sexuality studies that illuminate the frequency of various sexual behaviors and disorders among Christians in general.

5. Traditional life cycle theorists assumed marriage to be normative, but this should not necessarily be the case. For Christians who are called to be single, we acknowledge that they face an even greater challenge in reconciling their sexual feelings and struggles to a life of singleness.

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Religious objections to same sex attraction between men have existed since at least the Middle Ages1 but were first endorsed in law in England in the 1533 Act of Henry VIII, which classified sodomy as an illegal act between man and woman, man and man, or man and beast.2 This law, which was re-enacted in 1563, was the basis for.Â Male 4. The contrast between the depth of their sexual feelings and the simplicity of the treatment made many doubt the wisdom of the approach. Most became disillusioned and stopped the treatments themselves.Â Mainly that from a guilt-ridden Christian point of view it meant that at least I had tried to do something and it had proved not to work. I think it's mostly the feeling that I'd done my bit to try and deal with the problem. I found that comforting. Sex addiction as a disorder extends across the lifespan, beginning in adolescence as secondary sexual characteristics mature, conditional on presence of biological and personality factors (e.g., insufficient mesolimbic dopaminergic turnover reflective of risk-taking characteristics), and subjective affective discomfort, embedded within social environmental contexts that expose teens to sexually explicit stimuli and related social learning of the reinforcing value of.Â Therefore, familiarity with current models of treatment for sexual addiction and compulsivity will play a significant role in successful treatment of cybersex compulsives.Â Homosexual men were found more likely to have had cybersex compared with Millions of college students â€” both women and men alike â€” develop eating disorders during their college years. The vast majority don't seek help or don't realize the extent of their problem. Eating disorders are extreme behaviors, emotions, and attitudes that revolve around food and weight perceptions.Â If you're concerned, contact your mental health care provider to take an assessment, and ask yourself the following questions: Do you feel uncomfortable when drugs or alcohol are not available? Do you drink heavily when you are disappointed, distressed or get in a fight?