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ORIGINAL PAPER

Explanations for the Origins of Sexual Compulsivity Among Gay and Bisexual Men

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Abstract Sexual compulsivity (SC) is a condition characterized by sexual fantasies and behaviors that interfere with personal, interpersonal, or vocational pursuits. This article describes the ways in which gay and bisexual men with symptoms of SC understand and explain the origins of their condition. The data for this article were drawn from Project SPIN, a mixed-methods study of SC among 183 gay and bisexual men in New York City. The article provides an evaluation of how urban gay and bisexual men experience SC and describes how they think about it in their own words. These men articulated both intrinsic and extrinsic sources for the development of SC. Some participants endorsed a belief in a predisposition toward sexually compulsive behavior, whereas others identified factors such as emotional neglect, sexual abuse, or the availability and accessibility of sexual partners. These understandings may influence the ways in which SC can be treated, while also highlighting issues that may be critical in the identification and/or measurement of SC. Insights into the origins of SC may yield new therapeutic models that reduce not only the distress of contending with this condition but its negative health effects and impact on quality of life.

Keywords Sexual compulsivity · Gay men · Sexual risk taking

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Introduction

Sexual compulsivity (SC), also known as "sexual addiction" or "compulsive sexual behavior," is a clinical phenomenon characterized by sexual fantasies and behaviors that increase in frequency and intensity sufficiently enough to interfere with personal, interpersonal, or vocational pursuits (Muench & Parsons, 2004). Over the past 10 years, the rapidly expanding literature on SC suggests that the condition represents a discrete clinical problem (Black, Kehrberg, Flumerfelt, & Schlosser, 1997; Carnes, 2001; Goodman, 1998; Raymond, Coleman, & Miner, 2003). Symptoms of SC include exaggerated expressions of sexual behaviors, such as compulsive masturbation, excessive use of pornography, sex with multiple anonymous partners, excessive use of the Internet for sexual purposes, and disproportionate amounts of time thinking about sex or obsessing about a particular sexual partner (Black, 2000; Kafka, 1994; Parsons, Severino, Grov, Bimbi,

& Morgenstern, in press). Other symptoms associated with SC are low self-esteem, social anxiety, loneliness, intimacy problems, social skills impairment, guilt, sensation seeking, and additional impulse control problems (Black et al., 1997; Carnes, 1991; Gold & Seifer, 2002; Kafka, 1997; Kalichman & Rompa, 1995). People with SC report a range of adverse consequences as a result of excessive sexual thoughts and activity, including interpersonal conflict and distress, social and occupational problems resulting from absenting oneself from obligations in the pursuit of sexual activity, psychological distress, especially regarding self-esteem, and financial problems resulting from the costs of pornography, paying for sex, and loss of income from avoiding work responsibilities (Muench & Parsons, 2004). Finally, people with SC face physical health consequences, such as increased risk for HIV and other sexually transmitted infections (Kalichman & Rompa, 1995).

While other sexual disorders are listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), no specific classification for SC currently exists other than its potential to fall under "Sexual Disorders, Not Otherwise Specified" (APA, 2000). This absence is, in part, due to the competing diagnostic paradigms proposed by various investigators (Manley & Koehler, 2001). SC has been conceptualized as an addiction disorder, an obsessive-compulsive spectrum disorder, an affective disorder, and an impulse control disorder (Goodman, 1998; Morgenstern et al., in press; Raymond et al., 2003). This lack of clinical coherence negatively affects treatment options for a sizeable portion of those with SC, in terms of being able to assign a diagnosis, to obtain proper treatment, and to obtain insurance coverage for treatment.

The development of SC may be due to other psychiatric conditions. People with SC have extremely high rates of co-morbidity with other psychiatric disorders—rates similar to people entering outpatient treatments for other disorders (Raymond et al., 2003). Across studies, rates of various psychiatric disorders, specifically, mood disorders, anxiety disorders, and substance use disorders ranged from 64% to 81% (Black et al., 1997; Raymond et al., 2003). Some researchers and clinicians have argued that SC is a manifestation of other disorders such as bipolar disorder or personality disorders, especially borderline personality disorder (Black, 1998). Yet, the fact that no one cluster of other disorders appears to be associated more often with SC suggests that this condition represents a distinct clinical phenomenon with high co-morbidities. It is notable that rates of childhood sexual abuse among people with SC range from 30% to 78%, suggesting that this experience may be an important factor and, in fact, it has been hypothesized as an etiological factor in its development (Black et al., 1997; Carnes, 2001; DiMaria & Parsons, 2005).

Researchers and clinicians have identified persons with SC either through clinical interviews or self-report measures. Several measures for SC have been developed and have successfully discriminated both between those who self report SC and controls, and between varying levels of SC and prevalence of sexual thoughts and behaviors. Coleman, Miner, Ohlerking, and Raymond (2001) reported that a sexual control subscale successfully discriminated between a SC sample, a pedophilic sample, and normal controls. Kalichman and Rompa (1995, 2001) reported that higher scores on the Kalichman Sexual Compulsivity Scale (KSCS) were significantly associated with more sexual partners and greater sexual risk taking. Findings regarding the ability of the KSCS to discriminate those reporting out of control sexual behavior and those who do not have been replicated across numerous studies (Benotsch, Kalichman, & Kelly, 1999; Dodge, Reece, Cole, & Sandfort, 2004; Kalichman, Greenberg, & Abel, 1997; Kalichman et al., 1994; Kalichman & Rompa, 1995, 2001; Parsons, Bimbi, & Halkitis, 2001; Reece, Plate, & Daughtry, 2001).

Whereas researchers have estimated that SC exists in 3–6% of the total adult US population, the rates are significantly higher for men than women (Black, 1998, 2000). It appears that SC may occur even more frequently among gay and bisexual men (Baum & Fishman, 1994; Missildine, Feldstein, Punzalan, & Parsons 2005). There are several reasons why features of SC may differ and prevalence rates may be higher in such men. First, the majority of persons, regardless of sexual orientation, seeking treatment for SC are men (Black, 2000). Second, gay and bisexual men report more total sexual partners than heterosexual men (Quadland, 1985; Saghir & Robins, 1973). Third, the availability of gay-oriented sexual outlets, through venues such as bathhouses, sex parties, cruising areas, and more recently, Internet cruising for sex websites, may make it easier for gay and bisexual men at risk for SC to actually develop the problem (Parsons, 2005) and to trigger sexually compulsive episodes (Parsons, Kelly, Bimbi, Muench, & Morgenstern, 2007). This element of availability for sexual outlets functions similarly to the way in which higher incidences of pathological gambling emerge in populations with increased access to gambling opportunities (Volberg, 1994). It has been suggested that conflict and anxiety with regard to sexual orientation and societal homophobia make typical courtship difficult for gay men, which could lead to SC (Muench & Parsons, 2004; Pincu, 1989; Quadland & Shattls, 1987). The process of contending with SC may negatively affect self-esteem and happiness (Kalichman & Rompa, 1995). The ways in which sexually compulsive individuals conceive of their condition may impact these and other areas of health and well-being. For this reason, it is important to understand where individuals with SC perceive

their condition to originate as it may have implications for treatment.

While a variety of clinical explanations of SC abound in the literature, exactly how such individuals themselves explain the origins of their problems with SC has not previously been described. This article describes the ways in which gay and bisexual men with symptoms of SC understand and explain the origins of their condition. It provides an assessment of how urban gay and bisexual men think about their disorder in their own words and frameworks. These understandings may influence the ways in which SC can be treated and health and well-being maintained, while also highlighting issues that may be critical in the measurement and identification of SC. The data upon which this study is based come from Project SPIN, a qualitative and quantitative study of SC among gay and bisexual men in New York City. The overarching purpose of the study was to investigate the nature, antecedents, and course of SC in an urban sample of gay and bisexual men.

Method

Participants

The participants ranged in age from 19 to 63 years (M = 35.99 years, SD = 8.32). The majority were gay identified (89.6%). Men of color accounted for 40.4% of the final sample (18.6% African American, 18.6% Latino, remainder "other"). A quarter of the men (25.1%) reported being HIV positive, 5.5% reported never being tested for HIV, and 69.4% reported being HIV negative. A total of 36.6% of the men were currently in relationships with another man. Participants reported an average of 29.8 male partners in the 3 months prior to assessment (SD = 35.76, range, 2–250). Participants had a mean score of 31.86 on the KSCS (SD = 4.28, range, 24–40). Men reported an average of 12.3 h spent per week specifically searching for sex on the Internet, watched an average of 5 h of pornography a week, and masturbated an average of 9 times a week (see Table 1).

Table 1 Sample Characteristics (N = 180)

	M (SD)	Range
Age	35.99 (8.32)	19–63
Male sex partners in past 3 months	29.8 (35.76)	2–250
Kalichman score	31.9 (4.28)	24–40
Sexual internet activity	12.3 h/week	
Pornography viewing	5.0 h/week	
Masturbation	9.0 times/week	
Sexual identity	%	
Gay	89.6%	
Bisexual	11.4%	
Race/Ethnicity		
White	59.6%	
African-American	18.6%	
Latino	18.6%	
Asian/Pacific Islander	0%	
Other	3.2%	
HIV status		
HIV positive	25.1%	
HIV negative	69.4%	
Never tested	5.5%	

Procedure

To obtain a sample of gay and bisexual men with SC, both active and passive recruitment efforts were utilized in targeted sampling, a sampling methodology developed for studies of hidden populations in specific geographical districts (Watters & Biernacki, 1989). Targeted sampling was designed to "obtain systematic information when true random sampling is not feasible and when convenience sampling is not rigorous enough to meet the assumptions of the research design" (Watters & Biernacki, 1989, p. 420). Based on the targeted sampling method, recruitment strategies were implemented to obtain a diverse sample of sexually compulsive gay and bisexual men. During active recruitment in a variety of venues catering to gay and bisexual men (e.g., bathhouses, clubs, community events, bars), project staff approached potential participants to provide them with a brief verbal description of Project SPIN. Through passive recruitment efforts, potential participants were either handed flyers about the study at venues or saw project advertisements in gay community-based publications. Potential participants recruited through either strategy were provided with a telephone number to call to be screened for eligibility. To avoid self-labeling among potential participants, recruitment materials read "Is your sex life spinning out of control? Is sex interfering with your life? Are sexual thoughts getting in the way?" To supplement these recruitment strategies, participants were also recruited via the Internet—by which men were "approached" virtually in chat rooms and provided a description of the study—and through snowball referrals. Just over a third of the sample were recruited through passive methods (36.7%), followed by active recruitment (32.2%), referrals (21.3%), and the Internet (9.8%).

Participants were telephoned for initial eligibility screening during the project enrollment period from January 2002 through June 2003. Eligibility criteria included that the men were (1) age 18 or older; (2) identified as gay or bisexual; (3) and have had at least two male sexual partners

in the last 90 days. The final inclusion criterion was a score of 24 or above on the KSCS (Kalichman & Rompa, 1995). A score of 24 indicated high levels of symptoms for SC; this cut-off score was used to identify high SC individuals as it was the 80th percentile in previous studies (Benotsch et al., 1999). Self-identification as sexually compulsive or addicted was not an inclusion criterion.

A total of 364 men called for telephone screening, of whom 282 were deemed eligible. Those callers meeting criteria were then scheduled for an in-person assessment, at which time they were re-screened for eligibility. Of the 282, 37 did not show for their assessment, 23 were dismissed prior to completing the interview for inconsistent responses between the screening measure and the baseline assessment, and 6 exercised their right to voluntarily end their participation prior to completion. All eligible participants were paid $40 for their time to complete a 2–4 h assessment. Of the 216 participants who completed the assessment, 33 were dropped from the final analysis because they had inconsistent response patterns on self-report scales. Of the 183 remaining participants, 3 audiotapes were unable to be transcribed, resulting in a final sample of 180 men.

Trained staff interviewers administered the assessment to all participants. These interviewers received extensive didactic training on clinical interviewing and question intent. Staff participated in weekly interviewer meetings to further hone interviewing skills. They were trained to utilize the multiple interview forms of the assessment, which consisted of a qualitative interview, a semi-structured diagnostic interview for SC, a structured diagnostic interview for DSM Axis I disorders, and a multi-domain battery of self-report measures. Data for this article were elicited solely from the qualitative interview.

Measures

Qualitative interview

After completion of informed consent, participants were asked a series of open-ended questions regarding their problematic sexual behavior (Parsons et al., 2007). The questions sought to elicit terminology used to describe their problematic sexual behaviors (e.g., sexually compulsive, sexual addiction, etc.) and subsequently asked participants to explain their perceptions regarding the origins or phenomenology for the development of their problematic sexual behaviors. Certain key questions elicited much of the data analyzed for this article. During the course of the open-ended interview, all participants were asked, "Many terms and phrases have been used to describe people who feel their sexual behaviors are out of control. How do you refer to this?", "What does it mean to you?", and "To what do you attribute your (term used by participant)?" After each of these specific questions, the interviewers followed up with appropriate probes to elicit further data on these topics. The qualitative interviews were audiotaped and later transcribed.

Analytic procedure

All qualitative data produced from Project SPIN were transcribed and entered into a computer database. The research team was trained and supervised in coding procedures. Using NUDIST, a software program that enables the organization, coding, and analysis of large qualitative data sets, data were coded for a thematic analysis of the experience of SC and its impact on daily living. Thematic analyses have proven to be an effective method for evaluating qualitative data of many varieties (Miles & Huberman, 1984; Patton, 1990). Both open and axial coding procedures were utilized; the former was used to assess emerging themes from a grounded perspective and the latter to assess specific origins of SC suggested by the literature (Strauss & Corbin, 1998). Within these broad categories, key themes were identified; each emerging theme met a level of endorsement by multiple participants. All quotations utilized in the results section are direct, verbatim quotes from the participants.

The open coding procedures were utilized in several waves to build sub-codes linked to the larger codes developed during the previous waves. Inter-coder reliability was established using the procedure recommended by Smith (2000). A team of eight coders underwent repeated rounds of coding the same interview until >85% agreement was reached. Inconsistent codes were discussed and appropriate revisions made. Coding training was ceased on the sixth round when 86.7% agreement was established (Parsons et al., 2007). Subsequently, each coder was then assigned 20–25 unique interviews to code. After half the interviews were coded, another round of reliability coding was conducted, at which time inter-coder reliability was 86.5%.

Results

Of the 180 men interviewed, 12 did not provide usable data to questions targeting the origins of their SC. The lack of usable data largely resulted from responses to the questions about the origins of SC in which participants discussed issues other than their origins. A total of 22 men specifically stated that they could not explain the source of their compulsive sexual behavior. The remaining 146 men gave codable explanations of the roots of their SC. These men supported a variety of explanations for the origins of their disorder. Based upon the organic emergence of a dichotomous account of these origins, we classified their explanations under two major

categories, intrinsic explanations and extrinsic explanations, and examined the specifics of these categories.

Intrinsic explanations stemmed from some sort of internal problem the men located within themselves. A majority of the men interviewed (n = 82) proffered intrinsic explanations of the origin of their SC. Juxtaposed with the intrinsic explanations asserted by these men were extrinsic explanations. As opposed to the intrinsic explanations in which the men located the source of SC within themselves, extrinsic explanations emerged largely from the circumstances in which these men have found themselves. Fewer men (n = 35) interviewed asserted an extrinsic explanation of the origin of their SC. Twenty-nine of the men gave both extrinsic and intrinsic explanations suggesting that they believed in a multi-causal nature of their problem.

Intrinsic explanations

From our interview data, we identified five major intrinsic explanations of SC. The following descriptions illustrate the major intrinsic explanations.

Negative affect

Many of the men identified a connection between their mental well-being and their behavior. Some implied that depression caused them to behave badly, as if their awful feelings induced uncontrollable sexual behavior. One participant, a 35-year old Latino said:

> Well, it gets to be too much sometimes, the way, well, I'm, I get highly depressed a lot of the time so sometimes it gets to, to be too much and I act out. And usually it has to do with having sex or doing something like that.

For other men, sex was a means by which they filled the gaps in their lives related to their depression. SC became a means to self-medicate a depressive episode. A 34-year old white male put it this way: "I have gone through lots of times in my life when I felt anxious or depressed. So, I have used sex as a band-aid for those emotions." As another participant, a 38-year old White male, described, "It's a way of sort of self-medicating when I'm feeling depressed. And it's a surge of endorphins or whatever that makes me feel a little less anxious or less depressed afterwards." Whether acting out or self-medication, feelings of depression stimulated SC for a number of men.

Low self-esteem

Connected to the issue of depression, although not quite the same issue, was low self-esteem. Low self-esteem creates a situation whereby these men used sex compulsively to build themselves up or to take their mind off of a negative self-image. One 38-year old White male succinctly said, "My sense of it is it's a self-esteem problem." As a 44-year old Latino stated:

> It would make me forget about my loneliness, my low self-esteem, the fact that I don't think much of myself, the fact that I don't think I'm that attractive. You know that being with men would sort of boost my self-esteem.

Sex became a vehicle by which some men improved their self-image. The fleeting connections formed during sexual encounters provided some of these men with a sense that they were desirable and wanted. From this interpretation, the low self-esteem from within generated a need to find fulfillment through sex; successful attempts to procure sex boosted the deficient esteem.

A need for validation and affection

Some men believed the source of their SC was a need for validation. Unable to find validation in their social relationships, they found validation in sex. Sex provided a quick outlet for feeling desired and important. It provided such men with feelings of connection. As a 48-year old White male stated, "It could be the want of, of wanting to be with somebody, getting affection, giving it." Another participant, a 27-year old African American, described in it in a similar manner: "It stems from a substitute of love. Having affection, passion, which is very, very difficult in my life to get, or has been. The alternative, which is easy, is to get sex." Though some sought validation through sex, it was not a panacea. Even after finding sex, some of these men were left with an empty feeling. Though seemingly a quick, easy fix for affirmation, some men even felt guilty after realizing they were not truly fulfilled. As a 38-year old African-American described it:

> I want to be appreciated and I'm not getting the appreciation I need in my life through normal channels or whatever, so I use sex to fill the void. The irony is that it isn't. It's making the void worse.

Thus, men spoke in a variety of ways about SC as spurred on by a need to seek intimacy.

Stress release

Other men posited that their SC emerged as a means to deal with stress in their lives. For such men, sex was somehow the most reliable stress reliever. Stress could arise from various parts of their lives but sex remained a constant means of relief. The stress may not arise from a specific event, but general life experiences. Sex provided a specific outlet for release. A 31-year old White male declared, "It's like a way of dealing with stress and anger and frustration sometimes. Like, just put everything else aside and that's it. That's all." Sex was seen as a natural palliative by a number of men. A 33-year old White male described it in these words: "I think sex is a good stress reliever, in one capacity or another, masturbation or whatever...I think my life becomes more stressful with school, and sex is a way to relieve that." Though many avenues for stress release exist, these men chose sex. One man, a White 53-year old, for whom sex was his preferred means of relief, stated that "Some people go out and have a drink or smoke a joint...it's (sex) a great relief for me. It relieves the tension and I find it very easy, I'm not a man who likes to commit." The need to alleviate stress fueled the compulsive sexual behavior.

Biological

Some men asserted that the origins of their SC stemmed from some sort of biological process. Men making these assertions discussed genetics, hormones, drives, and other biological phenomena. These men believed they were subject to the forces of physiology, which caused them to operate in a sexually compulsive manner. A 21-year old African-American man noted, "I think it's my hormones. That's what I think; it's genetic." A 32-year old African-American man stated:

> It's probably just a high sex drive. That's the only thing that I can think of, that I just have a higher sex drive than most other people do, and for that reason, it's always a thought that I have.

Another man, a 37-year old White male, traced the biological roots of his SC back to genetic roots in his family history. He said:

> I don't know if this can be passed genetically or what not, but I know my father cheated on my mother, and my grandfather cheated on my grandmother. So, I don't know if that's possibly genetic as well. My dad's a big whore too, so I don't know.

Though clearly complicated, these men ascribed the origins of their SC to a variety of biological roots.

Extrinsic explanations

The following is a descriptive profile of the causal locales of SC for men who provided extrinsic explanations. The men who provided such explanations felt that there was a context to their compulsive sexual behavior. In many respects, though the feelings that produced the manifestation of SC appeared intrinsic, the causal locale of the origins of SC was external to the individual. Many of the men who described extrinsic explanations tied these explanations into their experiences. For example, the manifestations of SC could be caused by the experience of a traumatic break-up, the lack of something meaningful in one's life, or the experience of a failed connection with a parent as a child. Though these experiences related to the individual's subjective state of mind, the sources of those states were external. We elicited four major extrinsic explanations from our interview data.

Relationship issues

Some men struggled with being single, asserting that when they were not partnered, they acted sexually compulsive. Perhaps the lack of sexual stability and intimacy found in a relationship led such men to act compulsively to fulfill those needs. Alternatively, the particular social context of single life and the availability of other male sexual partners may set the stage for their development of SC. A 42-year old White male said:

> Well, I think that since I'm not in a relationship and I haven't been in a long time and rarely have been, you know, you can need that. Well, I do need that physical contact...It's just like a little hunger that has to be fed once in a while.

For other men, being single in a city full of available men facilitated compulsive sex. A White 32-year old described it this way:

> Because I'm not in a relationship and I like to have sex. So, it's like that's when I want, you know, to have sex. And, but it [being in a relationship] sort of prevented me from [having sex], because it's so easy to have sex in a city, especially.

The difficulty of contending with relationships, or the lack thereof, is attributed as the reason for the development of SC among some men.

Availability

As alluded to in the previous quote, some men believed that the roots of their SC stemmed from the sheer

availability of sex in New York City. For these men, life in a large city afforded numerous, anonymous contacts, which essentially operated as an amplifier for their sexual desires. Encountering high numbers of sexually available men stimulated their sexual desires. A 48-year old White male stated:

> I don't know it's just like all of a sudden, especially since I came, you know I moved here [New York City], I think it's probably all of a sudden I realized that I've got this major sweet tooth and living in this area just provided me with this incredible candy store. That's one way to look at it.

Echoing these sentiments, a 37-year old White man said:

> So, I know definitely ever since the Internet came around, I've been more [sexually compulsive] because it's so easy. Then I moved here. It's so, like I could find somebody every hour if I wanted to here in New York City. I think that's part of the problem, that it's so easily obtainable here.

Thus, for some men, the sheer availability of sexual outlets was a contributing factor to the origin of SC.

Childhood sexual abuse

Some men traced the roots of their SC to past traumas, mainly childhood sexual abuse. The experience of this trauma lingered either in their conscious minds or subconscious and it instigated the compulsion towards sex. A 32-year old Latino described how the sexual abuse he suffered at the hand of a family member influenced his SC. He said:

> My cousin...he had sex with me when I was eight. This cannot [be right], to me, since they open to this sexual world before an appropriate age. So it develops some kind of permanent pattern of behavior that I may not control.

Another man, a 34-year old Latino, stated:

> I think it began with my having been what might be called prematurely sexualized by my older brother when I was a boy. And I had sexual encounters with him, on more than one occasion. I don't know how many exactly, but it was disturbing pretty much each time we did that. And I think that was the beginning of it.

Thus, for men who reported childhood sexual abuse, these childhood sexual traumas were identified as the source of their current troubles with SC.

Parental issues

Some men believed that their SC has its origins in maladjusted relationships with their parents. The SC was a means to deal with these lasting issues. Some men related it to difficult or non-existent relationships with a parent. A 30-year old White male said:

> I think it's just sort of a relationship with my father that is non-existent and we didn't talk at all and he didn't know that I was gay and it sort of dawned on me. My roommate was telling his folks...that he was very free and I think there were hands were open for him and for me it was sort of like I was going around like searching for affection and love and stuff.

Others associated it with abandonment issues with their parents. Another man, a White 44-year old, said:

> My father and mother both died before I was 20. And my father for some reason disliked me. Took my two other brothers and sisters away, left me with the neighbors, wanted nothing to do [with me].

In contrast with sexual abuse, the social traumas associated with complex relationships between parent and child were identified as the source of compulsive sexual behavior by some men.

Discussion

The last two decades have offered significant advancements in the study of SC, revealing the complex components of the condition (Carnes, 2001; Kalichman & Rompa, 1995; Parsons et al., 2007; Wainberg et al., 2006). Although the first mention of pathological sexuality was during the 19th century (Black, 1998), there is currently no parsimonious diagnosis for such a condition. In contrast to other more common disorders, such as depression or schizophrenia, relatively little is known about the onset and course of SC. These particulars, including potential origins of this disorder, are imperative not only in treatment but also for identifying potential sufferers. Our findings suggest that men suffering from SC provided a wide range of accounts of the origins of their problem. The study participants offered both intrinsic and extrinsic explanations of the origin of their SC. Some participants endorsed a belief in a predisposition toward sexually compulsive behavior, whereas others identified more external factors, such as emotional neglect, sexual abuse, or simply the availability and accessibility of sexual partners. In addition, some of the men interviewed could not cite a source for their SC when queried by the interviewer. These lack of explanations highlight the ambiguity of the experience of SC and the complex nature of its

foundations. These varying perceptions of the origins of SC may have varying treatment implications.

For the men who reported intrinsic explanations for SC, we identified deep emotional connections to their condition. The compulsive nature of their behavior related directly to their sense of self and personal identity. As the source of the SC was perceived to lie within themselves, there exists a deep connection between the problem and their conceptions of who they are. Given this deep connection, a certain degree of identity transformation may need to occur in order to overcome the problem, as occurs with those in recovery from other addictions (Anderson, 1993). At the heart of these explanations focused within the individual lies the issue of accountability. For example, the men reporting origins in low self-esteem or negative affect expressed a certain amount of guilt in their discussions of the source of their SC. These men may struggle not only with the stress related to SC but also with stigma and feelings of being responsible for their own behavior.

The men who located the origins of SC in external sources placed distance between the problem and themselves. This disconnects the SC from their personal identity, but at the same time may diminish their sense of accountability over the problem. These conditions may diminish feelings of guilt and personal marginalization. However, such an externalized sense of control may inhibit help-seeking behaviors. Thus, individuals expressing extrinsic origins of SC may be less likely to experience personal marginalization, but also less likely to seek treatment.

Relevant literature supports both intrinsic and extrinsic potential origins of SC (Carnes, 2001). Childhood sexual abuse has been linked to later sexual risk taking and impulsivity in adulthood, perhaps as a way of reenacting traumatic events of abuse (Holmes, Foa, & Sammel, 2005; Whitfield, 1998), either searching for resolution for the original trauma or identifying with the aggressor. Alternatively, social and contextual factors, such as the availability of sexual partners, may trigger compulsive sexual behavior among gay and bisexual men (Parsons et al., 2007). The introduction of the Internet has only eased the availability of meeting partners, and viewing and purchasing pornography (Cooper, Delmonico, & Burg, 2000), particularly for gay and bisexual men (Parsons, 2005; Parsons et al., in press; Ross, 2005).

Axis I disorders, particularly mood and anxiety disorders, are commonly found in those with SC (Black, 1998; Kafka & Prentky, 1994). This strong correlation suggests a possible physiological influence for some men. The theory of a predisposing or genetic factor coincides with the biological or disease model of addiction and certainly sheds light on its course. However, from the biological model of addiction, there is no recovery, only complete abstinence from the addictive behavior (Begleiter & Porjesz, 1999). Clearly, as sexuality is an innate aspect of human behavior, recovery efforts remain a major challenge for the treatment of SC.

There are numerous diagnostic models for defining and explaining SC such as an addiction paradigm (Carnes, 1991; Goodman, 1998), impulse control disorders (Barth & Kinder, 1987; Black, 2000), and OCD spectrum disorder (Hollander & Wong, 1995). Although it appears that SC is a unique clinical phenomenon (Black et al., 1997; Raymond et al., 2003), these differing diagnostic paradigms highlight that SC can have a broad range of underlying symptomatology. An individual's subjective explanation is the basis for matching the specific needs of each client to an individualized treatment plan. In this way, clinicians can work from a bottom up approach which builds treatments to the problem rather than forcing a treatment scheme or diagnostic category that is poorly understood onto an individual.

One way this can be achieved is via a functional analysis of subjective proximal and distal triggers and causes of the behavior and the use of interventions designed to target those triggers. For example, for those individuals who report that their SC was primarily due to availability, environmental engineering may be an appropriate first step followed by addressing problems with impulse control. Alternatively, persons reporting hyperactive sexual drive may first be given selective serotonin reuptake inhibitors (Kafka, 1991; Wainberg et al., 2006), and then be taught counter-conditioning techniques to deal directly with sexual arousal. For those individuals who report low esteem or SC as a result of negative affect, increasing platonic social support in group settings and cognitive reframing may be treatment targets whereas cognitive exposure may be included in treatment if childhood sexual abuse is present. Regardless of one's orientation, using the client's subjective understanding of a problem is the logical entry point for any treatment that strives to build an empathetic therapeutic alliance. Once such an alliance has been established, clinicians can then foster an individual's responsibility for change regardless of the "reason" for their problem.

Research on the conceptual underpinnings of SC and effective treatments for this problem is still in its infancy. There is no universal standard of care or accepted diagnostic conceptualization that can guide clinical efforts. Understanding the diverse subjective explanations of SC is one of the initial steps for building a useful taxonomy of general and unique etiological factors of this problem and can help guide future efforts to create effective treatments for this heterogeneous population.

While we believe that the present research study captured an accurate portrait of its participants, it is important to consider the limitations of this study in evaluating the origins of SC. First, the results of this study are only generalizable to gay and bisexual men who described concern about their sexual behavior "spinning out of control"

and who scored a 24—well above a normal population mean—on the KSCS. Secondly, the study population was limited to men in the New York City area. This could be a potential confounder, considering the availability of sexual partners in a large metropolitan city.

Despite these limitations, the current findings have important implications for the diagnosis and treatment of SC. The condition generates uncontrollable sexual urges and behaviors of increasing frequency and intensity, which significantly interfere with daily functioning and affect quality of life of the individual (Carnes, 2001; Muench & Parsons, 2004; Parsons et al., 2007). These behaviors are impulsive by nature, and thus may involve risky behaviors and/or anonymous partners (Carnes, 2001; Kalichman & Rompa, 1995; Muench & Parsons, 2004). Given that SC is more prevalent men, and apparently more prevalent in gay and bisexual men, this may contribute to the public health crisis of HIV transmission through increased opportunities for unsafe sexual encounters (Carnes, 1991; Centers for Disease Control, 2005). Despite an overall decline in new HIV/AIDS cases over the past decade, the number of new HIV/AIDS cases in MSM has continually increased (Beltrami, Shouse, & Blake, 2005; Elford & Hart, 2003). At the height of the HIV/AIDS epidemic, where unsafe sexual contact remains the primary route of new infection, particularly among MSM, efforts need to be focused on prevention and treatment of this condition (Centers for Disease Control, 2005). Further insights into the origins and social course of SC may yield new therapeutic models that reduce not only the distress of contending with this condition but its negative health effects and impact on quality of life as well.

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