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FAMILY-OF-ORIGIN CHARACTERISTICS OF MEN WHO ENGAGE REGULARLY
IN SEXUALLY ADDICTIVE BEHAVIOR

by

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ABSTRACT

The present study surveyed men to assess whether any correlations existed between a man's sexually addictive behavior and how his family-of-origin addressed sexuality along with demographic factors. A total of 374 male participants (18 years or older) provided complete data sets via the online survey located on SurveyMonkey. The main research question for this study was as follows: Is there a relationship between demographic variables or family factors: (a) negative attitudes and communication about sexuality in one's family-of-origin, (b) exposure to sexual stimuli in one's family-of-origin, and (c) open sexual discussion in one's family-of-origin, and sexual addiction.

All three of the hypotheses of this study were supported. Hypothesis 1 predicted that higher levels of negative attitudes and communication about sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction. Hypothesis 2 predicted that higher levels of exposure to sexual stimuli in one's family-of-origin would correlate positively to a measure of sexual addiction. Hypothesis 3 predicted that less open sexual discussion in one's family-of-origin would correlate positively to a measure of sexual addiction. Data collection was accomplished by self-report surveys, Sexual Addiction Screening Test (*SAST*, Carnes, 1989), Family Sexuality Scale – Revised (*FSS-R*, Pfuetze & Cottone, 2013) and a demographic questionnaire. The *FSS-R* is a Likert-type scale that measures how one's family-of-origin handled the topic of sexuality. Correlational analysis was used to analyze whether there was a relationship between a man's sexually addictive behavior and how his family-of-origin handled sexuality.

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CHAPTER I

INTRODUCTION

The purpose of this study was to understand family-of-origin characteristics surrounding the sexuality of men who engage regularly in sexually addictive behavior. There has been a major increase of sexual addiction – both in reporting and in individual cases – in U.S. society in recent years (Albright, 2008; Carnes, 2011; Carnes, Delmonico, Griffin, & Moriarity, 2007; Cooper, Delmonico, & Burg, 2000a; Cooper, McLoughlin, & Campbell, 2000b; Cooper, Morahan-Martin, Mathy, & Maheu, 2002; Daneback, Ross, & Mansson, 2006; Ropelato, 2011). This study gathered information to improve the understanding of male sexually addictive behavior and the ways that family-of-origin factors might relate to sexual addiction. Research that addressed this issue was available, but most of it was either out of date, anecdotal, or did not provide empirical validation (Carnes, 1992; Laaser, 2002; Matheny, 2002; Phillips, 2006).

The pioneering work and influence of Patrick Carnes on the topic of sexual addiction underlay this dissertation. Carnes was seen by many as a prominent forerunner to the recognition of and research on the topic of sexual addiction (Adams & Robinson, 2001; Giugliano, 2009; Laaser, 1996b, 2003). Carnes saw sexual addiction as an intimacy disorder that was manifest in a compulsive cyclical pattern (Carnes, 1983). According to Carnes (1983, 1989, 1991, 2001b), those who were sexually addicted had an inability to adequately attach and bond in intimate relationships, a difficulty which was believed to be tied to family-of-origin issues (Carnes, 1983). Sexual addiction was believed to be the way one seeks to compensate for early family-of-origin problems and attachment failures, as well as for present day problems (Carnes, 1983).

It was believed by some that American culture was becoming more sexualized due to the Internet, where children under the age of 12 were being introduced to adult sexuality and sexual themes in age-inappropriate ways (Bale, 2011; Mitchell, Finkelhor, & Wolak, 2003; Mitchell, Wolak, & Finkelhor, 2007; National Center on Addiction and Substance Abuse, 2004; Ropelato, 2011; Wolak, Mitchell, & Finkelhor, 2007).

According to the American Psychological Association (2007), sexualization could happen in many different ways, one of those being when “sexuality is inappropriately imposed upon a person” (p. 1). Some estimates reported that the average child was first exposed to pornography between the ages of 9 and 11 (Internet Filter Review, 2003; Ropelato, 2011). This was thought by some to be the result of the ease of accessibility to Internet pornography (IFR, 2003; Ropelato, 2011).

Sabina, Wolak, and Finkelhor’s (2008) study of college students regarding their exposure to online pornography during adolescence showed that 93% of those surveyed were exposed to pornography prior to the age of 18, with exposure to pornography before the age of 13 being quite rare. A rapid increase in pornography use among 12 to 17 year-olds was also reported (Boies, Knudson, & Young, 2004; Braun-Courville, & Rojas, 2009; Finkelhor, Mitchell, & Wolak, 2000; Flood, 2009; Greenfield, 2004; Ropelato, 2011), with this age group being identified as the largest consumer of Internet pornography (IFR, 2003; Paul, 2005). There was believed to be an increase in U.S. society in sexual addiction and related behaviors (Albright, 2008; Carnes, 2011; Carnes et al., 2007; Cooper et al., 2000a; Cooper et al., 2000b; Cooper et al., 2002; Daneback et al., 2006; Ropelato, 2011), as well as a rise in sexual assault, which was believed to be

related to the Internet (Ropelato, 2011). This reality has greatly impacted U.S. society at all levels, including individuals, families, and local communities.

Common Family of Origin Factors

There was much theory and anecdotal evidence from therapists who worked in the area of sexual addiction, along with a limited amount of literature, indicating that men who engaged in sexually addictive behaviors commonly had family-of-origin histories that included certain factors, such as: being extremely rigid or silent about sexuality (Adams & Robinson, 2001; Schneider, 1989; Sprenkle, 1987), being extremely open with no boundaries on issues of sexuality (Carnes, 2000; Widmer, 1997), allowing for age-inappropriate sexual communication (Lefkowitz, 2002), and communicating about sexuality in negative or derogatory ways (Bersamin et al., 2008; Pawlowski, 2006). Both sides of the spectrum (family-of-origin either being extremely rigid or silent about sexuality, or a family-of-origin being extremely open with no boundaries on issues of sexuality) appeared to be related to the development of sexual addiction (Schneider, 1989).

Family Environments that Were Rigid or Silent about Sexuality

The rigid home tended to be ultra-conservative on sexuality issues. There were often rules regarding sexuality, without much explanation for the reason and purpose of such rules. Children were expected to obey and not question. This caused confusion for children, as well as intrigue regarding this “forbidden area” (Adams & Robinson, 2001; Schneider, 1989; Sprenkle, 1987). When the child began to act out or discover sexuality, there could often be negative consequences, particularly when there was no help or explanation from the parent to assist the child in understanding the normalcy of sexuality

and desire. This could easily cause children to feel great shame and have a need to hide their sexuality. If this was not handled or discussed in a healthy context, it was believed that it could become very destructive to the child as he or she passed through adolescence into adulthood (Adams & Robinson, 2001; Butler & Seedall, 2006; Giugliano, 2003; Sprenkle, 1987). This was thought to result in great damage to the area of one's sexuality, as shame and fear became associated with any desire, action, or thought related to sexuality.

Homes that were silent on the topic, and where sexuality was not discussed in age-appropriate contexts were believed to have the potential to lead to sexual addiction (Sprenkle, 1987). In such environments, children were left alone to interpret and understand their experiences regarding sexuality. This could have been very confusing for children, and could have caused them to feel shame as they began to encounter issues of sexuality both internally (such as puberty, increased sexual desires, and masturbation) or externally (such as pornography sites on the Internet, sexual experimentation, or sexual abuse) (Adams & Robinson, 2001). Children and adolescents needed the interpretation and guidance of adults to navigate this powerful and confusing issue (Adams & Robinson, 2001). They needed to understand the normalcy of their experiences and to be guided to appropriate and healthy behaviors.

Family Environments that Were Extremely Open to Sexuality

Family members that were extremely open to sexuality might have had no sense of boundaries in regards to the children in the home (Giugliano, 2006). The topic of sexuality tended to be very open in such environments, without any consideration of what was appropriate and healthy for children to hear and witness. In these homes, it was

common for parents to talk openly about their own sexuality, as well as sexuality in general, and to allow access to entertainment or Internet sites related to sexuality. There were often no boundaries or limits to what a child might have accessed (Giugliano, 2006). In these homes, it was common for members of the family to walk around naked, to exhibit their sexuality for others to see, or to communicate about sexuality in an age-inappropriate way in front of their children. It was believed that these homes had the potential to lead to sexual addiction (Sprenkle, 1987).

Family Environments that Were Negative and Derogatory in their Communication about Sexuality

Homes where it was commonplace for adult family members to communicate about sexuality in negative and derogatory ways might have led to sexual addiction (Giugliano, 2006). Such environments were thought to produce confusion, intrigue, and fear in children. As sexual beings, their curiosity and desires might have been incited (Giugliano, 2006). This awakening to sexuality was believed to have been premature, and without proper guidance it could have led a child to associate sexuality with shame, fear, and confusion (Giugliano, 2006). These emotions might easily have become a part of the framework of their sexuality later in adulthood, and could easily have had devastating consequences to their sexual behavior, leading possibly to sexual addiction (Giugliano, 2006).

Shame-based Families

Anecdotal evidence showed a correlation between men who engaged regularly with sexually addictive behavior and those men's family-of-origin environments (Carnes, 1992; Laaser, 2002; Matheny, 2002). Typical families and family environments related

to those who were sexually addicted often included patterns where children were regularly shamed for their behavior, thoughts, and sexuality (Carnes, 1992). This shaming could be either covert or overt and happened on a consistent basis. This mode of parenting created an environment that was unsafe and caused the child to internalize their shame and their related core beliefs (Carnes, 1992). This resulted in much insecurity later in life. These children began to believe they were the cause of any problems they experienced in most relationships and in other aspects of their lives (Carnes, 1992). They easily began to assume they, as people, were wrong and deserved punishment. This enticed them to seek to escape or to medicate their feelings of shame and despair. Sexual behavior could easily become a method of seeking relief if introduced at the right time (Butler & Seedall, 2006; Sprenkle, 1987).

Invalidating Families

It was believed that another typical family environment for those who later engaged in sexually addictive behavior was one where there was consistent invalidation from one's parents in regards to one's emotions, thoughts, sexuality, and/or personhood (Adams & Robinson, 2001). An invalidating environment was one in which a child grew up feeling that their emotional responses, thoughts, experiences, and desires were inappropriate, incorrect, unreasonable, and should not be trusted. These children felt worthless and believed that they did not matter. It was believed that this might have led to a desire to numb their feelings through different methods, one of those being the use of sexually addictive behaviors (Adams & Robinson, 2001).

Abusive and Non-abusive Family Environments

A family environment where there was abuse, or where the issue of abuse was

neglected rather than acknowledged, was believed to be another way that one might enter the path of addiction, including sexual addiction (Laaser, 2006; Schneider, 1989; Sprenkle, 1987). When one person treated another in an offensive, harmful, or damaging way, whether sexually, emotionally, and/or physically, that behavior had numerous devastating consequences that could easily set that person up for future problems with addiction. Addiction could become a way of escaping the memory, pain, and horrors of the past abuse (Laaser, 2006; Schneider, 1989).

Definition of Terms

Sexual Addiction

Carnes (1983) viewed sexual addiction as an intimacy disorder, consisting of behaviors and thoughts that were sexually related and compulsive and which interfered and negatively affected one's daily life and relationships (Carnes, 1983; 2005). Sexual addiction was a process that was degenerative, mood altering, unmanageable, and repetitive. Sexual behavior was pursued by the addict despite the harmful consequences that may have resulted in their life and relationships (Goodman, 1998; Laaser, 2000; Schneider, 2004). For sexual addicts, sex became a priority over other areas of life, and they became increasingly willing to sacrifice relationships and daily responsibilities in order to continue their sexual behavior. Carnes' view of addiction did not focus on a "specific behavior or substance, but on an unhealthy relationship to behavior or substance, which had the ability to alter one's emotional state" (Giugliano, 2009, p. 7). Sexual addiction was not defined by a specific type, form, or frequency of behavior, but by "the relationship between this behavior pattern and an individual's life" (Goodman, 1998, p. 2). Sexual addiction was present and real when one was unable to control one's sexual

behavior despite the severity of the consequences.

Sexually Addictive Behavior

Sexually addictive behavior was defined as the multitude of behaviors common to sexual addicts. Carnes (1983) deemed sexually addictive behavior to be sexual activity that was abusive, shameful, and/or secretive. There tended to be a pattern of out-of-control sexual behavior with resulting consequences and a growing sense that one was unable to stop (Laaser, 2000; Schneider, 2004). One slowly began to feel controlled by one's sexual desires and behaviors, especially when excessive time was spent seeking out sexual experiences either on the Internet or in daily life. Sexually addictive behavior was often compulsive, hidden, and out-of-control. The behavior was often kept secret through lies, manipulations, and justifications. It became the main strategy for coping with the struggles of life (Carnes, 2005; Laaser, 2000). Sexually addictive behavior became the coping strategy used to manage anxiety and other powerful emotions, as well as to medicate and escape from one's feelings and problems. It was also a way to feel important, powerful, and/or desirable (Carnes, 2005; Laaser, 2000).

Family of Origin

Family-of-origin was defined as the family in which one was reared. This usually consisted of a group of people who were related by blood, marriage, or a strong common bond.

Purpose of the Study

The purpose of this study was to determine whether there were any consistent family-of-origin characteristics in men who engaged regularly in sexually addictive behavior as well as to discover whether there were any associations between sexual

addiction and specific demographic factors. The intent of this dissertation was to improve the understanding of the ways that male sexually addictive behavior related to family-of-origin experiences and other demographic factors.

The literature showed that certain demographic factors such as race (Giugliano, 2003, 2008; Ragan & Martin, 2000; Robinson, 1999), relational status (Daneback et al., 2006; Cooper et al., 2000a; Cooper et al., 2000b), educational background, and socioeconomic status (Carnes, 1989; Marshall, Marshall, Moulden, & Serran, 2008; Marshall & Marshall, 2010) might have an association with sexual addiction. However, they are based on hypotheses, as no quantitative data were available. According to the literature, sexual orientation (Grov et al., 2008; Missildine, Feldstein, Punzalan, & Parsons, 2005), sexual abuse and physical abuse (Parsons, Grov, & Golub, 2012; see also Aaron, 2012; Anderson & Coleman, 1991; Carnes, 1991, 2000; Carnes & Delmonico, 2006; Coleman, 1991; Cox & Howard, 2007; Laaser, 2003; Rickards & Laaser, 1999; Schneider, 2000), were associated with sexual addiction. The researcher discussed this in greater detail in chapter two.

Focusing on how one's family-of-origin handled sexuality could be beneficial in many different ways. It could help therapists working with sexually addicted men, or those men struggling with sexually addictive behavior, to better understand their family-of-origin and begin to connect their addiction to their story. This could also be beneficial to parents as they guide and care for their children in an Internet culture that is highly sexualized. Understanding some of the dynamics that play a part in the formation of sexual addiction could help parents think through healthy paths of parenting, thus helping them prevent and protect their children from future sexual addiction.

The initial hypotheses of this study were as follows:

Research Hypotheses

Hypothesis I. Higher levels of negative attitudes about sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction.

Hypothesis II. Higher levels of derogatory/negative communication regarding sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction.

Hypothesis III. Higher levels of exposure to sexual stimuli in one's family-of-origin would correlate positively to a measure of sexual addiction.

Hypothesis IV. Less open sexual discussion in one's family-of-origin would correlate positively to a measure of sexual addiction.

This dissertation examined data for any correlations that might exist between a man's sexually addictive behavior and how his family-of-origin addressed sexuality. The hypotheses for this study were generally directional, as the literature indicated that certain family-of-origin characteristics related to and influenced sexually addictive behavior when children of these families reached adulthood.

Significance of the Study

In recent years, it is believed that there has been an increase of sexual addiction in American society in regards to individual cases (Ropelato, 2011; Carnes, 2011). There needs to be a greater understanding about the correlates and causes of sexual addiction in order to prevent this addiction and to better help those already struggling with it. Each person is shaped by his or her family-of-origin. Understanding the effect of family-of-origin on sexual addiction could better equip those who work with sexual addicts. It

would also be beneficial for sexual addicts as they work on their recovery. Research and anecdotal evidence indicated that one's family-of-origin might play a part in the formation of sexual addiction. There needs to be a better understanding of family-of-origin factors.

There was a limited body of research that specifically addressed the relationship between one's family-of-origin and sexual addiction. The strong anecdotal evidence needed to be empirically confirmed, supported, or disputed. This dissertation sought to fill research gaps and encourage future research in this area of study.

Conclusion

The evidence was quite limited in regard to specific research on family-of-origin characteristics regarding sexuality of men who exhibited sexually addictive behavior. Instead, one found anecdotal evidence from therapists working in the field. More research was needed to improve upon the anecdotal evidence. The research literature supported, in a limited way, the contention that sexually addicted behavior in men correlated with their family-of-origin and how their family members handled the topic of sexuality. This study expanded on the limited research that was already available and assessed whether there was a relationship between certain demographic factors, including the way sexuality was handled in a male's family-of-origin, and their sexually addictive behavior.

CHAPTER II

LITERATURE REVIEW

The objective of this literature review was to address and thoroughly review the literature related to the family-of-origin characteristics of men exhibiting sexually addictive behavior. Computer searches of ERIC, Psych Info, and Google Scholar were conducted, without limitations on dates, using key terms in different combinations. The key terms used were: “pornography,” “sex*,” “sexual addiction,” “famil*,” “family-of-origin,” “family system,” “characteristics,” “cybersex,” “trauma,” “sexual abuse,” “openness,” “communication,” “sexual communication,” “negative communication,” “permissive,” “permissiveness,” “sexual,” “age-inappropriate,” “sexual abuse,” “physical abuse,” “age,” “race,” “ethnicity,” “homosexual*,” “gay,” and “demographic factors,” where the symbol * represented a truncation that allowed for an accounting of all possible endings of a word. A separate and complete online search of the *Sexual Addiction & Compulsivity* journal (1998-2012) was completed, with each article being reviewed to make sure no relevant articles were missed and to determine whether they were relevant to the current study.

There were limitations in regards to the literature review. Not many articles specifically addressed family-of-origin characteristics of male sexual addicts. These ideas and categories were usually interspersed in articles or located in the midst of a different subject matter. Rarely was the topic being researched the sole focus of an article. Most of the literature regarding family-of-origin characteristics of men with sexually addictive behavior was based on theory, mainly from a psychodynamic

perspective. Any empirical data that were discovered were noted and explained in the review.

Sexual Addiction

Carnes (1983) defined sexual addiction as a “pathological relationship with a mood-altering experience” (p. 14) in connection with sexual behavior. Other scholars agreed with Carnes’ (1983) conceptualization of sexual addiction (Cooper, Golden, & Marshall, 2006; Corley & Schneider, 2003; Delmonico, 2005; Giugliano, 2009; Goodman, 2001; Laaser, 2003; Schwartz, 2004; Tripodi, 2006; Vesga-Lopez, Schmidt, & Blanco, 2007). Giugliano (2009) pointed out that Carnes’ (1983) view of addiction did not focus on a “specific behavior or substance, but on an unhealthy relationship to behavior or substance, which had the ability to alter one’s emotional state” (p. 7). Sexual addiction was believed to consist of behaviors that were sexually related and compulsive, and which interfered with one’s daily life and relationships (Carnes, 1983, 2005). For sexual addicts, sex became a priority over other areas of life, and they became more willing to sacrifice relationships and daily responsibilities in order to continue their sexual behavior. As with all addictions, sexual addiction was a process that was degenerative, mood-altering, unmanageable, and repetitive, “despite significant harmful consequences” to one’s life and relationships (Goodman, 2001, p. 197; see also Laaser, 1996a; Schneider, 2004). Sexual addiction was not defined by a specific type, form, or frequency of behavior, but by “the relationship between this behavior pattern and an individual's life” (Goodman, 1998, p. 2). It is important to recognize that a highly sexually active person is not necessarily classified as a sexual addict. Some people naturally have a stronger sex drive than others. Sexual behavior became an addiction

when it interfered with one's life and relationships, where there was a pattern of self-destruction and often high-risk sexual behavior that was continued despite the severity of the consequences. The sexually addictive behavior did not satisfy, and the addict came to a place where they felt they were unable to stop their behavior. When one was unable to control one's sexual behavior, despite the severity of the consequences, then addiction was present.

Sexual Addiction Cycle

The sexual addiction cycle is an important component to understand in regard to sexual addiction recovery. It is vital for sexual addicts to understand the sexual addiction cycle, as well as to notice how the pattern continually played out in their lives. The literature pointed to a common pattern of development for the sexual addiction cycle. The roots were often set in childhood traumatic experiences and one's family-of-origin. The child or adult desired to alleviate their psychological pain and distress. In order to do this, they searched for something with analgesic qualities that could dull the pain (Sprenkle, 1987). Initially, the agent provided some relief, but this relief was only temporary, as shame and loneliness began to resurface. Because of this, they returned to the "fix" to deal with the pain. This behavioral pattern became repetitive, and a vicious cycle developed, adding to the psychological pain and distress, and thus leading to a greater need to engage in the behavioral pattern for its analgesic qualities (Sprenkle, 1987).

The sexual addiction cycle began with the use of fantasy to alleviate one's feeling and perception of being rejected and excluded (Laaser, 2006). The cycle was often fueled by secrecy, shame, and the attempt to suppress sexual impulses that conflicted

with a person's restrictive and rigid background (Laaser, 2006). This attempt to suppress could have exacerbated the cycle due to the increase of shame and secrecy, making the behavior more appealing. For future addicts, acting out became the only way to regulate emotions and feel a sense of peace, safety, and pleasure. The shame and overwhelming emotions that arose upon acting out were often resolved or regulated only by returning to the sexual addiction cycle. Thus, eventually the addict might have only felt pleasure and safety when they were sexually acting out (Laaser, 2006). With families that were open in their communication about sexuality, the cycle might have looked very similar. It was believed that this type of upbringing might have made acting out so normal that one easily and naturally gravitated towards the cycle in order to deal with difficulties in life. The cycle became a common, natural occurrence for them in dealing with difficult emotions and experiences (Giugliano, 2006).

Common Factors in the Origin of Sexual Addiction

Throughout the literature, the development of sexual addiction was seen to have several factors. These factors were not found in every situation, but were extremely common. An early view of the root of sexual addiction connected it to attachment failures with primary caregivers in early childhood (Carnes, 1983, 1991; Schwartz, 1996). Sexually addictive behavior was a way one compensated for early attachment failures in life (Adams & Robinson, 2001). According to Phillips (2006), many clinicians and researchers proposed that family-of-origin characteristics influenced sexual addiction, but they did not show empirical validation for these views (see also Carnes, 1992; Laaser, 2002; Matheny, 2002).

Childhood traumas, especially sexual, physical, and emotional abuse, were extremely common experiences in the lives of many sexual addicts (Laaser, 2006; Schneider, 1989; Sprenkle, 1987). Addictions of some sort were often found in the sexual addict's family-of-origin (Levert, 2007; Matheny, 1998). Neglect, abuse, abandonment, or invalidation by one's family-of-origin, as well as pervasive parental rejection, were common themes in the childhood experiences of sexual addicts (Adams & Robinson, 2001). It was common to observe in the family-of-origin of sexual addicts a family intimacy dysfunction, whereby the family-of-origin lacked closeness, intimacy, and safety among family members (Adams & Robinson, 2001; Carnes, 2000). The family was often rigid, restrictive, and disengaged (i.e., rigid rules, insufficient nurturing) (Schneider, 1989). Extremely conservative attitudes in the family-of-origin, along with their effects on the child, were other elements noted in the literature that were commonly found in the childhood experiences of sexual addicts (Adams & Robinson, 2001; Butler & Seedall, 2006; Giugliano, 2003; Sprenkle, 1987). The literature also described psychological preconditions that were discovered in those who had developed addictive patterns (Giugliano, 2003). These included a childhood marked by dissociation, as well as feelings of inadequacy, inferiority, and low self-esteem.

Shame

Only a few articles in the literature review referenced shame. Shame was a central component to sexual addiction and was often the fuel that drove and perpetuated the sexual addiction cycle (Adams & Robinson, 2001; Laaser, 2006; Sprenkle, 1987). According to Adams and Robinson (2001), shame (i.e., "I am bad, unworthy") (p. 24) rather than guilt (i.e., "I have done bad things") (p. 24), was the driving force behind the

addictive system. Shame was seen as one of the three barriers that prevented the establishment of successful intimacy in sexual addicts (Adams & Robinson, 2001).

Adams and Robinson (2001) saw shame as the principal feeling that the sexual addict sought to address and mediate. Addicts attempted to mask the pain of their shame by the peak of pleasure found in the cycle of addiction. Once the cycle ran its course, both the shame and guilt became even more intensified, and the need to mask the pain increased. The cycle became self-perpetuating and began to grow in intensity.

The literature showed that the shame most addicts felt came from three main sources: (1) childhood trauma (especially sexual abuse) (Sprenkle, 1987; Schneider, 1989; Laaser, 2006), (2) inadequate early developmental caretaking (Adams & Robinson, 2001), and (3) the continued cycle of sexual addiction (Sprenkle, 1987; Laaser, 2006). Addicts internalized their experience of shame, and it became the “lens” through which they saw all things. This further alienated the addict from themselves as well as from others. This alienation from others, and the increase of shame, was thought to draw the addict to further reliance on the addiction in order to cope with the internal and relational distress (Adams & Robinson, 2001). Shame became a part of the sexual addict’s identity. A shame-based personality had often already developed in the future addict, even before sexuality became an issue (Sprenkle, 1987). This was most evident in the life of a sexual addict who grew up in a highly restrictive home, where conservative attitudes were held regarding sexuality (Sprenkle, 1987; Widmer, 1997; Carnes, 2000; Giugliano, 2006). These types of homes tended to interpret what was ordinarily viewed as normal sexual behavior as being deviant and sinful. This could easily have set one up to see sexuality as a deeply shameful concept (Sprenkle, 1987). There was also some indication that shame

could have become a part of the identity of a sexual addict who grew up in a home that was permissive in attitudes toward sexuality (Carnes, 1991, 2000; Adams & Robinson, 2001).

Shame and identity formation were believed to have been very connected in the life of a sexual addict. Adams and Robinson (2001) believed that shame, resulting from trauma in early childhood (i.e., neglect, abuse, abandonment, or enmeshment), was rooted in and connected to the formation of one's identity. Without proper guidance and interpretation from a trusted adult, it was believed that children might have begun to blame themselves for the failures of their caretakers and to interpret those failures as a result of their own personal inadequacy. This feeling of inadequacy and failure could have been reactivated later during emotionally vulnerable and stressful times of life (Adams & Robinson, 2001). The needs, feelings, and desires of such children became shame-based. The shame they experienced became a part of their core identity and affected how they saw their feelings, needs, and sexuality (Adams & Robinson, 2001). For the sexual addict, shame was thought to have merged with the individual's arousal template during critical developmental periods (Carnes, 2001b). This was often believed to occur due to sexual abuse and other sexually shameful events in childhood. Because of this, it was believed that addicts tended to seek sexual experiences that were shame-based and unique to their trauma history (Adams & Robinson, 2001). For addicts, according to Adams and Robinson (2001), the addiction became a way to try to compensate for perceived and real failures and to hide the core shame they felt both from themselves and others. Addicts used their addiction to mend, fix, repair, and/or punish themselves (i.e. self-contempt). Adams and Robinson (2001) believed it was very

difficult for addicts to regulate their shame and other painful emotions without the addictive cycle. There was no empirical evidence in the literature to back up Adams and Robinson's (2001) assumptions, only anecdotal evidence coming from many clinicians.

In sexual addiction therapy and recovery, it was vital for the therapist to help clients counter their unhealthy belief system and develop strategies to help reduce the client's shame. According to Adams and Robinson (2001), the core shame needed to be felt, processed, and worked through, while false beliefs about oneself and others were challenged and new healthy beliefs restored. The therapist should help the sexual addict to create new and healthy intimacy skills. Shame needed to be a major focus during therapy, as it was one of the root issues underlying sexual addiction.

Invalidation, Rejection, and Abandonment

A person's childhood environment, whether it was validating or invalidating, was believed to play a part in the development of sexual addiction (Adams & Robinson, 2001; Carnes, 2001b; Linehan, 1994; Schwartz & Southern, 1999). An invalidating environment was one in which children grew up feeling that their emotional responses, thoughts, sexuality, and/or personhood were not correct, appropriate, reasonable, or justifiable. Over time, this was thought to result in great confusion for children and to lead to a general distrust of their own emotions, thoughts, and experiences. Linehan (1994), the developer of Dialectical Behavior Therapy, and Heard (1994) believed that invalidating environments were an environmental factor often leading to sexual addiction (Adams & Robinson, 2001). Self-empathy and self-care were important elements in one's ability to bond with others. In an invalidating environment, the child "does not internalize a caring relationship with self" and "tends to develop negative core schemas

or beliefs about the self” (Schwartz & Southern, 1999, pp. 167-168). These beliefs could easily have become self-perpetuating and affected how these children related to others and how they organized and processed interpersonal relationships. Over time, this was believed to develop into an intimacy disorder that could have easily led into sexual addiction (Carnes, 2001b; Schwartz & Southern, 1999).

When a child grew up with an invalidating caretaker, the child often internalized the invalidating actions and responses, beginning a pattern of invalidating themselves just as they were invalidated by the caretaker. This could have laid the foundation for an intimacy disorder and sexual addiction. Schwartz and Southern (1999) emphasized the damaging consequences of such an environment. They said that if a child’s need for affection, attention, validation, and discipline, among other appropriate parental behaviors, remained unmet, or if there was invalidation, absence, or rejection, “the consequences can be structurally written into the developing personality” (Schwartz & Southern, 1999, p. 164). It was believed that these children might have become emotionally constricted, turned into themselves, and began to disconnect from others, or became “emotionally dysregulated, failing to learn to utilize others to soothe or comfort themselves” (Schwartz & Southern, 1999, p. 164). Schwartz and Southern (1999) believed that this increased vulnerability to psychopathology and the tendency to seek out familiar relational environments in the future. Because of this, they began to recreate and reenact similar rejections, frustrations, and themes in new relational contexts. This further isolated them and began to cement negative core schemas. Sadly, this behavior repeated itself over time and became self-perpetuating.

Invalidation and failure in early developmental caretaking by one's primary caregivers was thought to lead to attachment failure, which was believed by Carnes (1983, 1991) and Schwartz (1996) to be a major source and root of the origin of sexual addiction (see also Adams & Robinson, 2001). According to Adams and Robinson (2001), sexual addiction could have been a way to compensate for early attachment failures. Often, the consequence of attachment failure was the inability of the child to soothe personal feelings of anger, sadness, loneliness, and fear. No empirical data were available, but it was believed that the individual's inability to regulate strong affect (i.e., affect dysregulation) might have become connected to the practices and behaviors of the natural function of sexuality, where orgasm and pleasure helped soothe internal distress (Adams & Robinson, 2001). This became a prime place for the addiction cycle to take root.

At this point, it was easy for a person to seek "self-medication" in a compulsive behavior that could have been used to both numb and distract the individual from past trauma that intruded into their life (Schwartz & Southern, 1999). Schwartz and Southern (1999) pointed out that this was where addictive behavior could have become a "coping mechanism" to help deal with difficult and unsettling emotions as well as the "lack of internal self-cohesion" (p. 171). "Acting out" for the sexual addict could have served as a way to release suppressed emotions related to past injustice and harm. The sexually compulsive behavior could also have helped to reduce anxiety and lead the individual into a "self-medicated 'high'" (Schwartz & Southern, 1999, p. 171). One's "acting out" became a way to self-soothe and later began to define the person as it turned into compulsive, addictive behavior.

Arousal Template

The “arousal template” was emphasized often in Carnes’ work (Carnes, 2001b) and referred to those things, such as images, thoughts, behaviors, sounds, sights, smells, fantasies, and objects, that aroused one sexually (Carnes et al., 2007). People unconsciously created patterns during their childhood, adolescent years, and beyond that determine what they found sexually arousing (Carnes et al., 2007). A person reacted unconsciously to the sexual stimuli that were represented in their arousal template. It was common to all people and was an integration of many experiences in one’s life, such as abuse, family history, courtship development, and sexual history. As an individual grew up, their life experiences, sexual experiences, and what they have learned about sex was incorporated into a sexual belief system and template (Carnes, 2001b). The template also consisted of what a person learned and experienced about relationships within the family environment. It was believed to be built on certain genetically determined preferences and was the guide one used to determine what one viewed as erotic (Carnes, 2001b). Both the decision making process, as well as the template one used, were believed to be unconscious to the individual (Carnes, 2001b). Anything in one’s life experience could have influenced the arousal template. Though limited primarily to Carnes’ work (1983, 2001b), the literature pointed to the concept of the arousal template connecting one’s past life experiences, including one’s family-of-origin, to present sexually addictive behavior.

Core Beliefs

A common theme in the literature was the development of negative core beliefs learned in one’s family-of-origin and how they played into sexual addiction. Children, it was believed, learned their core beliefs about their sense of self primarily in their family-

of-origin (Matheny, 1998). This could have been both negative or positive depending upon their specific experience in their family-of-origin (Matheny, 1998). Throughout life, people with addictions developed core beliefs about innate shame (Carnes, 2001b). The painful shame they carried could have become a part of their identity and often reflected childhood trauma they experienced (Carnes, 2001b). These core beliefs affected how they perceived reality and became the driving force for their addiction (Carnes, 2001b). Examples of “core beliefs” about one’s own innate shamefulness include, “I am basically a bad, unworthy person” and “No one would love me as I am” (Sprenkle, 1987, p. 12). Carnes (1983), pointed to four typical core beliefs found in sexual addicts. They often believe: (a) they are not worthwhile, (b) no one would love them for themselves, (c) they can’t trust others to fulfill their needs, and (d) sex is their most important need. An interesting point found in the literature was that people with addictions not only shared these common core beliefs, but that their co-addicts also shared them, which perpetuated the family dysfunction (Matheny, 1998).

In sexual addiction, core beliefs were often connected to sexuality. Certain sexual disorders, such as sexual addiction, tended to emerge when children believed they were “bad, defective, or damaged” and then began to attribute the “source of their badness” to their genital sexuality (Schwartz & Southern, 1999, p. 167). These core beliefs, which were primarily learned in their family-of-origin, could have caused great harm to one’s view of sexuality and gender, and they could have potentially led to issues of sexual addiction (Schwartz & Southern, 1999).

Affect Regulation and Maladaptive Coping

Another barrier that prevented sexual addicts from establishing healthy intimacy was the inability to regulate their affect. Adams and Robinson (2001) believed this inability was related to one's family-of-origin and early childhood experiences. They believed the development and perpetuation of sexual addiction came from a "catalytic sexual event" (Adams & Robinson, 2001, p. 37) that helped to alleviate one's inner turmoil, as well as helping to regulate strong affective states. Besides the regulation and relief of painful emotions, one also experienced pleasure due to the sexual behavior in which one engaged. This became an incentive and motive to continue with the behavior, even in the light of negative consequences (Adams & Robinson, 2001). The pleasure derived from engaging in sexual behavior was an additional benefit to the relief from painful experiences. The pleasure associated with the continued and escalating involvement with sexual behavior became "the inducement to continue beyond the point that negative consequences are experienced" (Adams & Robinson, 2001, p. 37). An example of a "catalytic sexual event" in a sexual addict's life might have been the discovery of pornography and masturbation at an early age during the midst of family turmoil and abuse, a discovery that brought a rush of excitement as well as an escape from the horrors of family life. This medicative escape from the chaos of home life helped to alleviate one's experience of inner turmoil, as well as helping to regulate strong affect. This powerful event, and succeeding events, could have led to the development of sexual addiction. This new discovery of a sexual behavior that helped regulate affect and brought pleasure could have easily become the thing towards which one started to gravitate in order to relieve emotional instability.

Adams and Robinson (2001) pointed to Goodman's (1999) proposal that addiction was the result of the impairment of the self-regulation system. This system had three primary functions:

(1) Affect Regulation Functions: these include the ability to avoid becoming overwhelmed by strong affective states with the use of self-soothing, self-enlivening, and self-arousal balancing skills. (2) Self-Care Functions: these involve an individual's ability to provide protection and nurturance to oneself.

The ability to recognize high-risk or dangerous situations and to respond appropriately is a self-protective skill. The ability to recognize and articulate needs and to set priorities to meet them is a part of self-nurture. (3) Self-

Governance Functions: these involve having internal beliefs, values and standards that contribute to the experience of appropriate esteem and a cohesive and consistent sense of self. (Adams & Robinson, 2001, p. 36, 37)

It was believed that impairment of the self-regulation system could have led the individual to an over-reliance on external things, such as sexual behavior, to help regulate the self (Adams & Robinson, 2001). In other words, the breakdown of the self-regulation system could have played a major part in the development of addictive behavior.

Similar to the concept of affect regulation was the notion of maladaptive coping, which was very common in the lives of addicts. These responses were developed in childhood due to unhealthy experiences with a caregiver and became a way to soothe and comfort oneself during times of emotional upheaval or confusion. This pattern of maladaptive coping created a mistrust of others to meet one's needs and predisposed the individual to rely primarily on external behavior in order to cope with environmental

stressors and emotional demands (Adams & Robinson, 2001). This was a prime setup for addictive behavior. Many sexual addicts did not learn to cope with their emotions well, and as a result were often left in an unhealthy place with the anger they felt due to wounds and injustices of the past. They were full of bitterness and resentment, lack forgiveness, and they longed for justice and revenge to prevail. Anger from one's past and present that was not handled properly and was acted out in a sexual way might have turned into eroticized rage that was thought to lead to sexual addiction (Carnes, 2001). Understanding, naming, and working through these maladaptive coping patterns in therapy was believed to be essential for healthy recovery (Carnes, 2001).

Family Factors and Sexual Addiction

Openness to Sexual Communication

Restrictive families. A highly restrictive and conservative attitude toward sex was a common family dynamic in the lives of many sexual addicts (Sprenkle, 1987). The family culture was one where sex was not discussed in healthy, appropriate ways. Sex was connected to shame and fear, and family members were forbidden to discuss the topic except in ways that were ultimately unhealthy and inappropriate. In this type of family, a child's feelings and thoughts regarding sexuality were not normalized, and they were viewed as inappropriate topics for discussion. The standard for appropriate sexuality was often set so high that over time the person was thought to be unable to conform to these attitudes, and thus began to interpret what would regularly have been considered normal and appropriate behavior as aberrant and sinful.

This often exacerbated the shame-based personality that had already begun to develop, even before sexuality had become an issue (Sprenkle, 1987). It also caused the

future addict to become highly secretive about his sexual behavior and suppress any sexual impulses. Ultimately, this suppression made those impulses more compelling (Sprenkle, 1987). The cycle of addiction began and continued to grow as one tried to hide from and deal with this shame. The addiction cycle and shame became self-perpetuating as addicts continued to cope with and manage their emotions. The literature also showed that disengaged families-of-origin with rigid rules and insufficient nurturing were common family backgrounds among sexual addicts (Carnes, 1988; Schneider, 1989). According to Carnes' (1988) research, where he studied sexual addicts and their families over a seven-year period, 68% ($n = 1,000$) of sexual addicts fell into the rigid, disengaged family category (see also Schneider, 1989).

The literature (Coleman, 1991; Greenfield, 2004; Levert, 2007) was limited in the area of sexual addiction and family environments that were highly restrictive regarding sexuality. Coleman (1991) briefly pointed out that sexual addiction had been linked to highly restrictive environments surrounding the topics of sexuality and intimacy. According to Greenfield (2004), children from families that treat sex as taboo are often seen as more vulnerable to the "influences of sexually explicit media than those reared in homes where sex is a permissible subject of conversation" (p. 747). Greenfield (2004) did not specifically refer to sexual addiction. However, as stated in other parts of the literature review, vulnerability followed by access to sexually explicit media could have easily led to sexual addiction.

Levert (2007) described a common behavior of sexual addicts during childhood where they learned to avoid reality and the hard things of life. Their childhood homes were often authoritarian, restrictive, and rigid in nature, where one or both parents were

addicted to some degree or the other (Levert, 2007). According to Levert (2007), the addictive behavior that was modeled for them by their parent(s) demonstrated the need to escape from life and to deny and pretend that problems did not exist. The denial of their problems often led them down a path where they saw their family system as healthy and normal, even though it was quite rigid and restrictive (Levert, 2007). According to Levert (2007), the child's denial, lack of honesty, and tendency to hide prevented them from developing important intimacy skills. This behavior set them on a course of hiding and denying reality. It also brought them to a place where they did not seek help for their struggles, but instead sought to cope through sexual addiction (Levert, 2007). More research was needed in this area in order to understand how families that were highly restrictive regarding sexuality influenced the adult child's sexual addiction.

Permissive families. The literature (Carnes, 1991, 2000) was quite limited in regards to sexual addiction and family environments that were permissive in their attitudes regarding sexuality. Carnes (2000) found that more than 87% ($n = 251$) of the patients treated for sexual addiction were raised in family environments that were disengaged, where family members were uninvolved, detached, or emotionally absent. Carnes (2000) believed this was a clear sign of an intimacy disorder that was often associated with sexually addictive behavior. This type of family environment was believed to easily have led to children growing up with intimacy problems and having difficulty meeting their own emotional needs (Carnes, 2000). Another study by Carnes (1991) showed similar results in that 68% ($n = 139$) of the sexual addicts in the study were also from disengaged families. Though these families were not overtly permissive, their uninvolved and detached parenting could easily have communicated, in a passive

manner, permissiveness to their children. More research was needed to see if sexually permissive environments in one's family-of-origin specifically related to later sexually addictive behavior in the adult child.

Family Sexual Communication

Sexual education. An important distinction was made in the literature regarding the difference between sexual communication and sexual education (Warren, 1995). Warren (1995) noted that communication was “bidirectional, involving two partners in mutual dialogue” (p. 173), where the opinions of both people were valued. Education, according to Warren (1995), was unidirectional, where the information was disseminated in a “top-down manner, from expert to novice” (p. 173). Warren (1995) addressed these concepts and pointed out that sexual communication “implies the co-creation of meaning about sexual beliefs, attitudes, values, and/or behaviors between persons exchanging messages” (p. 173). Warren (1995) stated that when parents educate their teenagers about sexuality, the process must provide accurate information as well as require “receptivity on the part of the listener and mutual regulation of information flow as understandings change” (p. 173; see also Rosenthal & Feldman, 1999). Parents need to communicate and engage their teenagers with a willingness to hear and understand their views and perspectives, rather than quickly dismissing them. To communicate effectively about sexuality with their children, parents need to approach them in a warm and humble way that seeks to understand and listen as well as imparting appropriate and accurate information at the right time.

The literature showed that it was common for parents to avoid discussing important issues about sexuality with their children (Pawlowski, 2006). Because of this,

it was believed that children tended to learn about sexuality from potentially harmful and unreliable sources, such as their friends, siblings, the Internet, and other media sources (Pawlowski, 2006). These sources of information might very well have been in disagreement with the parents' views on sexuality. Not having the proper guidance from their parents could have easily set children up for sexual difficulties and behaviors that could have potentially caused great harm (Pawlowski, 2006). Because of this, Pawlowski (2006) believed it was vital for parents to initiate and engage in sexual communication with their children. Greenfield (2004) believed that those raised with little sexual education tended to be more vulnerable to the influences of pornography and sexually explicit media than those who were raised with an adequate level of sexual education through childhood and the adolescent years.

Different perceptions on communication level. With respect to family communication about sexuality, there were different perspectives and accounts on the amount, nature, and quality of communication between parents and teens (Rosenthal, Senserrick, & Feldman, 2001). The literature pointed strongly to the notion that conversations between parents and adolescents regarding sexuality were not perceived in the same ways (Feldman & Rosenthal, 2000; Lefkowitz, 2002). Parents tended to report more notable and meaningful communication with their teenagers regarding sexuality than their teenagers reported (Fisher, 2001). Parents also believed their messages about sexuality were clearer than they actually were (Fisher, 2001). A couple of studies in the literature regarding parent-child communication about sexually related topics, have tended to report solely on one individual of the relationship, which was often the child (White, Wright, & Barnes, 1995). The dissimilarity between the child's report and the

parents' report on sex-related communication was common, as the parties had different perspectives on what was communicated (Feldman & Rosenthal, 2000; Jaccard, Dittus, & Gordon, 1998; Lefkowitz, 2002). Parents tended to evaluate themselves more positively than their children did on how they handled and conveyed sexual topics (Feldman & Rosenthal, 2000).

Infrequency of parental communication. Rosenthal and Feldman (1999) were surprised by the results from their study, which showed that parental communication with their children about sexuality was uncommon and rare. Though it was widely believed that parents should have been the primary source of sexual education to children, the literature indicated this was not the case (Abrams, Abraham, Spears, & Marks, 1990; Ansuini, Fiddler-Woite, & Woite, 1996; Rosenthal & Feldman, 1999; Rosenthal & Smith, 1995). When parents did communicate with their children on the topic of sexuality, they tended to focus on "issues relating to physical development and sexual safety rather than more psychological, relationship-based topics, or those that might be deemed to be personal" (Rosenthal & Feldman, 1999, p. 836). Rosenthal and Feldman (1999) pointed to common reasons for why parents felt uncomfortable talking to their children about sexuality. These included feeling embarrassed and uncomfortable, never feeling that there was an opportune time, having inadequate sexual knowledge, or believing their child would be unreceptive to their approach to conversation about sexual things (Rosenthal, & Collis, 1997; Rosenthal & Feldman, 1999; Warren, 1995).

Indirect communication by parents. Sexual communication in the family, between parents and children, could have taken place through direct communication, but the literature pointed to indirect communication being an important way parents

communicated knowledge about sexuality to their children (Lefkowitz, 2002). This had not been addressed much in the literature. Other than Lefkowitz (2002), no study had explored this topic. Some of the indirect communication that takes place in families regarding sexuality was believed to occur when parents allowed their children to watch media with sexual content (Lefkowitz, 2002). This could have easily, in an indirect way, communicated that this behavior was acceptable. All of this could have happened with or without the parents' awareness. Another indirect form of sexual communication was when "dirty jokes" were spoken or accepted (Lefkowitz, 2002). Parents might have also indirectly and unwittingly communicated acceptance of sexuality through their attitude towards nudity and how they showed physical affection in public (Lefkowitz, 2002). Thus, it was common for parents to send messages about sexuality to their children without ever having a specific conversation on sexuality.

Results of parental communication. Parents who were proactive about discussing topics of sexuality with their children helped to protect them from potential future negative sexual consequences (Bersamin, Todd, Fisher, Hill, Grube, & Walker, 2008; Karofsky, Seng, & Kosorok, 2000). Karofsky, Seng, and Kosorok (2000) pointed out that adolescents who reported more positive communications with their parents regarding sexuality tended to delay their engagement in vaginal intercourse than those who reported negative communication with their parents. Bersamin et al. (2008) pointed to contrary results, where parental communication about sex was actually "positively associated with initiation of both oral and vaginal sex" (p. 107). Bersamin et al. (2008) believed that a possible explanation for this positive association was that "parents who

anticipated their children would soon become sexually active” were much more likely to engage in sexual discussions (p. 107).

The literature pointed to a common phenomenon regarding parental communication about sexuality. Fisher (2001) noted that adolescents who had a high degree of communication with their parents about sexuality had “sexual attitudes highly correlated” (p. 544) with the parents with whom they had discussed sexuality, whereas those adolescents who had minimal communication with their parents about sexuality did not have sexual attitudes associated with the parent with whom they most discussed sexuality (Fisher, 2001). Fisher (2001) showed that older adolescents tended to incorporate the sexual values of their parents when their parents had discussed in a consistent and healthy way their own sexual values with their children. This supported the notion that parents could influence their children’s sexual values by how and when they discussed them (Fisher, 2001).

Sexually healthy families. Parents in sexually healthy families considered sexual communication and education to be important (Corley, 2005, p. 249). It was believed that sexually healthy families had parents that were approachable, proactive, and sought to use teachable moments with their children (Corley, 2005). The members of these families knew that their behavior and actions spoke louder than their words, and they believed that their behavior should have been consistent with their values (Corley, 2005). Sexually healthy families understood and allowed for privacy and a respect for boundaries (Corley, 2005). They allowed children to ask parents questions, prepared adolescents for puberty, and allowed adolescents to make age appropriate decisions (Corley, 2005). Corley (2005) also pointed out that sexually healthy parents were aware

of the “difference between childhood and adult sexuality,” (p. 249) and they knew what a mature sexual relationship looked like.

Greenfield (2004) asserted that the best way to deal with the challenges of a pornographic and sexualized media environment was through a “warm and communicative parent-child relationship” (p. 741). Healthy, open communication between parent and child was seen to be helpful and constructive in dealing with sexual matters (Greenfield, 2004). Miller, Benson, and Galbraith (2001) believed that a warm, safe, and communicative relationship between a parent and child was more important than even the discussion of specific sexual topics. A warm and communicative relationship between parent and child was seen to reduce sexual risk-taking (Greenfield, 2004). A healthy, open communication style in one’s family was shown to be helpful in mitigating the effects of moral judgments of 13- and 14-year-olds regarding pornography exposure (Greenfield, 2004). A number of articles in the literature reported that adolescents desired their parents to be “open, supportive and empathic in their communications about sexuality” (Rosenthal et al., 2001, p. 464; see also Brock & Jennings, 1993; Neer & Warren, 1988; Warren, 1995). There was a diversity of opinion in the literature regarding the effect of “open, positive, and frequent parental communication about sex” (Rosenthal et al., 2001, p. 465).

According to Lefkowitz (2002), there were “very few longitudinal studies of sex-related communication, and thus, most developmental data are based on cross-sectional samples” (p. 53; see also Kahlbaugh, Lefkowitz, Valdez, & Sigman, 1997). Without the longitudinal data, Lefkowitz (2002) believed it was too “difficult to understand the

dynamic nature of parent-child communication about sex-related topics” (p. 53). More research was needed on this dynamic and its effects.

Negative or Derogatory Communication on Sexual Matters

Sexual communication was mentioned in the literature in general ways, but on the specific topic of negative and derogatory communication in the family environment, the literature was extremely limited. Nothing was directly mentioned regarding this topic, but the literature did address the opposite notion, i.e. healthy sexual communication in family environments. Corley (2005) saw parental support and care being an important part of sexual education, that provided an opportunity for parents to share some of their own past experiences with their children. Pawlowski (2006) recognized the power of sexual communication in the home as being either good or bad depending on the direction the conversation took. Because of its strong influence, healthy sexual communication was believed to be vital, and thus needed to take place in families with sensitivity and care (Pawlowski, 2006). Parental communication regarding sexuality was a powerful protective element for adolescents, who felt safer talking about sexuality with their parents when the communication lines were positive (Karofsky et al., 2000). This often delayed adolescent sexual behavior, which was in contrast to families where there was a regular occurrence of negative sexual communication between family members (Bersamin et al., 2008). In families with a regular occurrence of negative sexual communication between family members, there was believed to be an increase of early sexual behavior (Bersamin et al., 2008).

A number of articles indicated that adolescents wished their parents were more empathic, supportive, open, and patient in regards to their communications about

sexuality (Brock & Jennings, 1993; Neer & Warren, 1988; Rosenthal et al., 2001; Warren, 1995). Greenfield (2001) pointed to the importance of a parent-child relationship being safe, warm, and communicative, as it was helpful in reducing adolescent sexual risk-taking (see also Miller et al., 2001). Greenfield (2004) also pointed out that one of the most important means a parent could have used to help their child navigate the challenges of the “sexualized media environment” was the fostering of a consistent, warm, communicative relationship with their child, which encouraged healthy communication in the family. A number of studies reported that frequent parental communications about sexuality were often associated with healthy and responsible sexual outcomes (Jaccard & Dittus, 1991; Leland & Barth, 1993; Pick & Palos, 1995; Ward & Wyatt, 1994). In contrast to this, Miller (1998) (see also Rosenthal & Feldman, 1999) believed there was no connection between the amount or style of how parents communicated to their children about sex and later adolescent sexual behavior.

Lefkowitz (2002) identified an important concept regarding communication about sexuality between parents and children. Though there were direct ways that a parent could have communicated to a child, indirect communication was another important way parents might have sent messages to their children (Lefkowitz, 2002). Indirectly, a parent could have communicated a negative or derogatory perspective regarding sexuality without even intending or realizing that was what they communicated. These indirect communications tended to occur more frequently than direct conversations about sexuality (Lefkowitz, 2002). Overall, the literature was extremely limited, without any direct mention of negative and derogatory sexual communication in the family environment.

Exposure to Pornography and Sexual Stimuli

When considering the literature regarding the relationship between exposure to pornography during childhood and sexual addiction in adulthood, it was important to first define what the literature means when it referred to “pornography” and “exposure.” Pornography was commonly defined as sexually explicit media showing “genitals and sexual activities in unconcealed ways” that were “primarily intended to sexually arouse the audience” (Flood, 2009, p. 385). Exposure, in reference to pornography, referred to “deliberate and accidental, voluntary and involuntary, viewing of pornography” (Flood, 2009, p. 385). There was an increasing amount of scholarship referring to the growing numbers of children exposed to pornography (Flood, 2009), as well as a growing concern in scholarship regarding the damage that occurred in the “social and psychological development of children and adolescents exposed to Internet pornography” (Mesch, 2009).

The literature pointed to a common dilemma in the research field surrounding the effects of pornography exposure upon children and teens. The majority of pornography studies have almost solely been conducted with adults “due to the ethical and legal considerations of exposing children and adolescents to potentially harmful material” (Ybarra & Mitchell, 2005, p. 474; see also Mitchell, Finkelhor, & Wolak, 2003). Due to these obvious legal, ethical, and practical elements, great restrictions have been placed on such research (Flood, 2009). Because of this, the body of research that focused on the impact of pornography consumption among children and young people was quite small (Boies et al., 2004; Braun-Courville et al., 2009; Mitchell et al., 2003). Beyond clinical observation, there was not much information available on sexually compulsive behavior

in adolescents (Boies et al, 2004). In line with Boies et al. (2004), Braun-Courville et al. (2009) pointed out that there were few studies on the impact of pornographic Web sites on “adolescent sexual attitudes and behaviors” (p. 157). Mitchell et al. (2003) also pointed out that no research had been conducted on whether exposure to pornography and other sexual material caused psychological, moral, or developmental harm to children.

Upon review, the literature did not provide much information on the impact of pornography exposure among children and teenagers (Braun-Courville & Rojas, 2009). The impact of pornography on adolescents was also highly debated due to the limited scientific research (Braun-Courville & Rojas, 2009). Some cross-sectional studies were available, and these were believed to have indicated that prolonged exposure to pornography in adolescence might have led to “exaggerated beliefs of sexual activity among peers, sexually permissive attitudes, and sexual callousness, including more negative attitudes toward sexual partners” (Braun-Courville & Rojas, 2009, p. 157).

The literature pointed to a number of statistics surrounding the relationship between exposure to pornography during childhood and sexual addiction in adulthood. In the United States, the average age of those who were first exposed to pornographic images on the Internet was 11 years old (IFR, 2003). Sabina, Wolak, and Finkelhor (2008) surveyed college students regarding their personal exposure to Internet pornography before the age of 18. The study showed that “ninety-three percent of boys ($n = 179$) were exposed to online pornography during adolescence,” with exposure to pornography prior to the age of 13 being quite rare (Sabina et al., 2008, p. 691). Different articles pointed to the adolescent years as the age where the viewing and accessing of pornography was common. The literature showed that the age group

between 12 to 17 years old was the largest consumer of Internet pornography (IFR, 2003). Forty-two percent ($n = 1,422$) of adolescents in America between the ages of 10 to 17 reported exposure to Internet pornography during 2007 (Wolak, Mitchell, & Finkelhor, 2007). Ybarra and Mitchell (2005) reported that 87% ($n = 106$) of adolescents who purposely looked for sexual images online were 14 years of age or older. Children under the age of 14, who were intentional in their pursuit of pornography, were more likely to be exposed to it through traditional means such as magazines and movies (Ybarra & Mitchell, 2005). Overall, the literature showed that those in their adolescent years were more proactive and prolific in accessing pornographic images than other age groups.

A major piece of the literature surrounding the relationship between exposure to pornography during childhood and sexual addiction in adulthood related to the topic of children being exposed to unwanted pornography without searching for it (Duimel & de Haan, 2006; Flood, 2007, 2009; Sabina et al., 2008; Soeters & van Schaik, 2006). No research specifically addressed the impact of unwanted or unexpected exposure to pornography among children and adults (Mitchell et al., 2003). Mitchell et al. (2003), in referencing a national survey of youth between the ages of 10 and 17, indicated that 25% ($n = 1,501$) of the youth had experienced “unwanted exposure to sexual pictures on the Internet in the past year” (p. 330). Mitchell et al. (2003) believed that this unwanted exposure of children and teens to pornography challenged the common assumption that problems related to pornography were associated with young people who actively sought it out. Mitchell et al. (2003) also pointed out that the majority of the youth from the previously mentioned national survey did not report negative reactions to the unwanted

exposure to pornography, while a quarter of the participants in the study reported being very or extremely upset.

Wolak, Mitchell, and Finkelhor (2007) in a study of 1,500 youth (51% male) aged 10 to 17 years (mean age 14.24 years; SD: 2.09 years) reported that, “Forty-two percent ($n = 603$) of youth Internet users had been exposed to online pornography in the past year” with 66% ($n = 400$) of those reporting unwanted exposure (p. 247). Another survey showed 45% ($n = 262$) of the 15 to 17 year-olds who had unexpectedly accessed pornography were “very” or “somewhat” upset by the unwanted exposure (Flood, 2009). Wolak et al. (2007) also reported another study that showed preteen boys having “considerable unwanted pornography exposure (17% ($n = 31$) of 10- and 11- year-old boys)” (p. 247). Unwanted exposure to online pornography increased over the years, rising from 25% in 1999 to 2000 to 34% ($n = 203$) of youth Internet users in 2005, with increases among all age groups, including between the ages of ten to seventeen years (Wolak et al., 2007).

Unwanted exposure to online pornography was occurring more frequently, as people were tricked into thinking they were going to a non-pornographic website, but instead they got diverted to an online pornography website. The unwanted exposure to online pornography happened in a number of different ways. Some of those included links to pornography sites that came up when a misspelled Web address or search was typed into a search engine and followed. Links within Web sites, spam email, and pop-up advertisements were other ways that unwanted exposure to online pornography could have occurred (Wolak et al., 2007). The degree of “unwanted exposure” pointed to a new phenomenon that was much less of an issue prior to the development of the Internet.

Before the Internet, there were not many places for youth to access pornographic material on a regular basis (Wolak et al., 2007).

Adolescents exposed to pornography experienced different emotional responses depending on the age of exposure to the sexual medium. According to Sabina et al. (2008), few adolescents felt extreme affects due to pornography use. Boys, in referring to their experiences with pornography, reported being shocked and needing to deal with guilt, shame, and “unwanted thoughts about the experience” (Sabina et al., 2008, p. 693). Greenfield (2004) pointed out that boys, age 12 or younger, responded to pornography mainly with embarrassment, fear of being caught, and guilt. Greenfield (2004), in referencing one study on the impact of sexual media on children and adolescence, noted that the memories of their experiences were “overwhelmingly negative,” with common emotional responses being disgust and shock (p. 743).

The evidence was clear from the literature that pornography exposure among children and teens influenced sexual violence (Flood, 2009). According to Flood (2009), exposure to pornography during adolescence was believed to have contributed to the sexualization and objectification of girls and women. The use of pornography was also shown to have had an adverse effect, such as an increase and higher rate of sexual aggression in boys. According to the Kaiser Family Foundation Survey (2001), 49% ($n = 1,209$) of older adolescents who consistently viewed Internet pornography tended to promote “negative attitudes towards women” (p. 34). Early and long-term exposure to pornography was believed to relate to male sexual aggression against women (Flood & Hamilton, 2003). This connection was strongest with the viewing of violent

pornography, but frequent users of non-violent pornography were shown to express sexual aggression against women as well (Flood, 2009).

Greenfield's (2004) review of the relevant literature showed that pornography could very likely influence sexual violence in children and youth. Both high frequency of pornography use, and the consumption of pornography that was violent, were shown to be "associated with sexually aggressive attitudes and behaviors among adolescent and older boys" (Flood, 2009, p. 393). Older adolescent boys that were already at a "high risk for aggressive behavior" tended towards a higher rate of sexual aggression upon the use of pornography (Greenfield, 2004, p. 744). Adolescents who were exposed to media that sexualized girls and women were "associated with greater acceptance of stereotyped and sexist notions about gender and sexual roles, including notions of women as sexual objects" (Flood, 2009, p. 391).

The increase of pornography exposure among adolescents was seen as an important factor influencing adolescent sexuality and health (Bale, 2011). Unfortunately, little research was conducted in this area (Bale, 2011). Pornography use was shown to influence the "users' attitudes towards and adoption of particular sexual behaviors" (Flood, 2009, p. 390; see also Thornburgh & Lin, 2002; Zillmann, 1989). Those who accessed pornography were influenced by it in their attitudes, in the sexual behaviors in which they chose to partake (Flood, 2009; Thornburgh & Lin, 2002; Zillmann, 1989), and in the "acceptance and adoption of particular sexual practices, relations, or identities" (Flood, 2009, p. 390).

The literature pointed out that frequent pornography exposure produced a greater knowledge of sexuality and "liberal sexual attitudes" (Flood, 2009, p. 390) among

children and teenagers (APA, 2007; Huston, Wartella, & Donnerstein, 1998; Strasburger & Wilson, 2002; Thornburgh & Lin, 2002; Ward, 2003). Young people who used pornography were more likely to have experienced early sexual involvement, sexual intercourse, masturbation, same-gender sex, one-night stands, and anal intercourse (Flood, 2009; Haggstrom-Nordin et al., 2005; Johansson & Hammarén, 2007; Rogala & Tyden, 2003; Tyden, Olsson, & Haggstrom-Nordin, 2001; Tyden & Rogala, 2004) than those who do not use pornography (Huston et al., 1998; Strasburger & Wilson, 2002; Ward, 2003; Wingwood, DiClemente, Harrington, Davies, Hook, & Oh, 2001). According to Boies et al. (2004), therapists anecdotally reported a high percentage of their sexually addictive clients having viewed pornography at an early age. This was in contrast to Štulhofer, Jelovica, and Ružić (2008), who found no connection between sexual addiction in adult men and early exposure to pornography. Another group that commonly experienced early exposure to pornography were child sexual abusers (Simons, Wurtele, & Durham, 2008). According to Simons et al. (2008), 65% ($n = 132$) of child sexual abusers were exposed to pornography before the age of 10.

Braun-Courville and Rojas (2009) believed that adolescents who were exposed to Internet pornography were more likely to be “associated with high-risk sexual behaviors,” such as “anal sex, multiple sexual partners, and substance use during sex” (p. 160). They also speculated that adolescents who frequented pornographic web sites were “more likely to possess sexually permissive attitudes and acceptance of casual sex” (Braun-Courville & Rojas, 2009, p. 160) and “display higher sexual permissiveness scores compared with those who have never been exposed” (p. 156). Exposure to pornography was also seen as a major factor that would increase a child or teenager’s

vulnerability to sexual abuse (Flood, 2009; Russell & Purcell, 2005). Pornography exposure was also noted as a common method used by adult perpetrators of sexual abuse to groom children and teenagers to be their victims (Flood, 2009; Russell & Purcell, 2005).

An interesting, but extremely rare element found in the literature was the perspective that pornographic material and media could have had positive effects on children and young people. Pornography and other sexually explicit material were seen as potential educational tools regarding sexual knowledge (Helsper, 2005; McKee, 2007). Explicit sexual material and pornography were also seen as valuable in offering a sexually positive challenge “to sexual repression and restrictive sexual norms” (Duggan, Hunter, & Vance, 1988, p. 75; see also McNair, 1996). Flood (2009) challenged the notion that pornography could be a beneficial tool, viewing it instead as a poor educational tool regarding sexuality, for he considered it to be too explicit for younger children and maintained that it often “shows sex in unrealistic ways and neglects intimacy and romance” (p. 394,395). Flood (2009) also saw it as a poor sexual educational tool in that it was often sexist, and because certain forms of pornography eroticized violence (Flood, 2009).

Age-inappropriate Sexual Communication

The literature pointed to a common occurrence regarding communication in the family environment surrounding the topic of sexuality. It was common for family members, for instance parents and teenagers, to have different accounts regarding what was discussed concerning sexuality, as well as the nature and quality of the conversations (Rosenthal et al., 2001). This discrepancy made it difficult to understand what truly

occurred in family communication, as there were often at least two reports and perceptions that were quite different. The literature did not directly address the topic of age-inappropriate sexual communication in family environments, but instead primarily addressed the opposite notion, i.e. the effects of age-appropriate discussion of sexuality in family environments. The literature showed that parents played an influential role in determining the course of their children's views on sexuality and sexual behavior (Fisher, 2001; Greenfield, 2004). This influence tended not to appear until late adolescence (Fisher, 2001). The literature, in regards to parental engagement and communication with children regarding sexuality, was also shown to be quite limited (Rosenthal & Feldman, 1999).

According to Lefkowitz (2002), the most common way parents communicated with their children about sexuality was in indirect ways rather than through direct statements addressing sexual topics. Indirect communication was an important and powerful way to send messages to children. Lefkowitz (2002) noted that when parents allowed their children to watch movies or television shows with sexual content, or when they joked about sexual matters in the presence of their children, they sent an indirect message to their children about sexuality. Though the message was not intended to explicitly teach about sexuality, a message was nonetheless communicated to the child about what was acceptable and appropriate (Lefkowitz, 2002). Even the physical expression that parents showed towards one another or their attitude towards nudity sent a message about what type of behavior was considered acceptable (Lefkowitz, 2002). According to Lefkowitz (2002), no studies explored the ways in which parents sent indirect messages to their children about sexual topics. Lefkowitz (2002) believed

further research was needed, especially in regards to how parents send indirect messages to their children through media exposure, as well as the types of unfiltered sexual conversations that might have occurred in the presence of their children. The indirect messages that were sent to children about sexuality could have easily been age-inappropriate. The literature did not explicitly state this, but it could have been deduced from Lefkowitz (2002). According to the literature, there were no longitudinal studies related to sexual communication surrounding the parent-child relationship. Without longitudinal data, Lefkowitz (2002) believed it was “difficult to understand the dynamic nature of parent-child communication about sex-related topics” (p. 53).

Demographic Factors Associated with Sexual Addiction

Age

The literature was limited in regards to the relationship between age and sexual addiction. The available scholarship pointed to a number of different views on the age of onset of sexual addiction, as well as the ages where sexual addiction tended to be most problematic. According to Carnes (1991), sexually addicted males began their addiction at an average age of 10 years old, often in light of experiencing childhood abuse. Goodman (1993) believed the average age of onset for sexual addiction was during the teen years or during the early 20s. A few years later, Goodman (1997) clarified his assessment; stating that the onset of sexual addiction was 18 years old and that it became most problematic between the ages of 20 and 30. Cooper, Putnam, Planchon, and Boies (1999) did not believe sexual addiction had an onset at any specific age. Kuzma and Black (2009) believed that sexually addictive behavior typically began by late adolescence or early adulthood. Though there were differing views in the literature

regarding the age of onset of sexual addiction, the experts typically saw onset in the teen years and early 20s, with Carnes (1991) being the exception, stating the average age of onset at 10 years old.

Ethnicity/Race

A review of the literature showed that most of the research on sexual addiction was unrelated to any specific culture. The research was quite limited on the effects of sexual addiction among minority groups. Giugliano (2008) stated that there was “no research on sexual addiction among people of color” (p. 149). Ragan and Martin (2000) pointed out that cultural and ethnic differences regarding sexual addiction were virtually unknown. A majority of the literature was generic in relation to the population studied, with only a few articles hinting that they had a Caucasian population base. Very few articles in the review acknowledged that their studies were limited by the lack of racial and ethnic diversity among the population studied. Though some extrapolation from certain studies onto different cultures might have been permissible, there needed to be caution in this area. Real discernment and knowledge of the specific culture needed to be taken into account when extrapolating this data to other cultures.

Giguliano (2003) emphasized that sexuality took on different meanings “in different times and cultures” (p. 275). Unfortunately Giguliano (2003) did not expound on this thought, but he raised an important point about sexual addiction, multiculturalism, and counseling. When counseling from a multicultural perspective, one needed to view sexual addiction in light of the culture. Sexual addiction in one culture might not have been considered as such in another culture. Unfortunately, in all of the literature reviewed by the researcher in this study, only Robinson (1999) addressed this point.

Robinson (1999) emphasized the need for clinicians “to develop an understanding of the many and varied cultural influences that enter into the therapeutic relationship” regarding sexual addiction (p. 12). More discussion was needed on the definition of sexual addiction from a multicultural perspective and its implications for counseling.

As stated above, the vast majority of the articles, minus Robinson (1999), never addressed sexual addiction from a multicultural perspective, but rather addressed it from a Caucasian perspective. According to Robinson (1999), sexual addiction literature with respect to the African American experience was largely anecdotal, or it was extrapolated from other literature focused on other client populations (p. 12). Robinson (1999) added, “Ethnic variables in sexual addiction have never been treated independently of other variables and have largely been assigned a covariant or secondary status” (p. 12). The purpose of Robinson’s (1999) article was to help the therapeutic community understand the variables related to sexual addiction in the African American community and the need to be culturally specific when working with minorities (p. 11).

Robinson (1999) desired to help clinicians see the need for the development of culturally sensitive, specific approaches that address common strategies in post-traumatic stress disorder (PTSD), such as numbing and avoiding. Robinson’s (1999) main focus was the positive correlation between the “African American status in America and the incidence of symptoms associated with PTSD” (p. 13). He linked PTSD in the African American community with sexual addiction as a source of coping with past and present trauma. Robinson (1999) believed that sexual addiction was a “technique by which African Americans respond to situations, events, or conditions that are reminiscent of their unremembered past” (p. 18). He emphasized that PTSD did not describe the

African American community as a whole, but believed that clinicians needed to be mindful of this when working with African Americans who dealt with sexual addiction (Robinson, 1999, p. 14). Robinson (1999) stated that it was essential in the treatment of sexual addiction among African Americans that therapists understand the “psychological impact of trauma on individuals from this group” (p. 15), especially the “role of slavery and the subsequent racist ideologies that followed slavery as perpetuating discrimination and exclusion of an entire group of people” (p. 15). He maintained that these events brought psychological trauma upon the African-American community (Robinson, 1999). Robinson (1999) believed that therapists needed to understand and keep this in mind, as the evidence was clear on the link between trauma and PTSD with sexual addiction (see also Carnes, 1991; Evans & Sullivan, 1995; Schwartz & Galperin, 1996). Greater understanding of the link between PTSD and sexual addiction would have greatly impacted clinical work in the area of sexual addiction in the African American community (Robinson, 1999).

It was unfortunate that the literature was scarce in the area of the effects of sexual addiction on ethnicity, especially with respect to minority groups. The bulk of what literature was available was either generic to the population studied or alluded to the fact that the population under study was predominately Caucasian. The lack of representation of other ethnic groups in the literature limited the counselor’s ability to address and assist with sexual addiction in these populations. More research was needed on the influence and association of ethnicity to sexual addiction.

Relational Status

The literature was also quite limited in the area of the relational status of sexual addicts. Two studies, Daneback, Ross, and Mansson (2006) and Cooper, McLoughlin, and Campbell (2000b), both showed that sexual addicts were more likely to be in a relationship. Cooper, Delmonico, and Burg (2000a) found that 80% of the sexually addictive respondents in their study were either married, in a committed relationship, or dating. Cooper et al. (2000b) also showed that those who were married were “less vulnerable to cybersex compulsion” (p. 22), while those who were single and dating were more likely to fit the category of cybersex addiction (p.12). This seemed to indicate that one’s sexual behavior, whether online or offline, had some association to one’s relational status. No explanations, only hypotheses, were given for these results.

Though not specifically talking about sexual addiction, Dew, Brubaker, and Hays (2006) pointed out that married men might use online sexual behavior as a way to cope with and escape from the pressures of life. Married adult males were also discovered by Dew (2003) to dissociate from depression, anxiety, and other negative emotional states when acting out their sexual addiction. Dew et al. (2006) believed that sexually addicted married men might act out sexually online, as there were fewer stigmas to meeting a sexual partner online versus in person, due to the ability to stay hidden and anonymous. According to Dew et al. (2006) the Internet had become a common venue for married men to solicit sexual partners without much risk of exposure (p. 202).

Dew et al. (2006), in alluding to sexually addictive behavior, pointed to the appealing nature of the anonymity and accessibility of the Internet for homosexual and bisexual men who were in heterosexual marriages to meet potential male sex partners.

The Internet provided a “safe” place for homosexual and bisexual married men to meet other men and seek out sexual partners without being “outed” (Dew et al., 2006, p. 203). According to Dew et al. (2006) the research was still quite sparse regarding the online sexual behaviors of married men. More research was needed on sexual addiction in light of relational status.

Educational Background

No literature was available on the educational background of sexual addicts. Research was needed in this area to provide further understanding of whether there was any connection between educational background and sexual addiction.

Socioeconomic Status

The researcher found a limited amount of literature on the socioeconomic status of sexual addicts. Only three pieces of literature (Carnes, 1989; Marshall et al., 2008; Marshall & Marshall, 2010) addressed this issue directly, and they referred to sexual addiction in light of the middle and lower socioeconomic class. Carnes’ (1989) study, though quite definitive because it was one of the first studies related to sexual addiction, was limited in that the research subjects were only from a middle class socioeconomic status. Marshall et al. (2008), on the other hand, showed a greater presence of sexual addiction in the lower socioeconomic status group at 17.9% compared to Carnes’ (1989) estimate of 3-6% prevalence of sexual addiction in the general population. Marshall and Marshall (2010) were confident, due to their previous research (Marshall et al., 2008), that sexual addiction was more of a problem in males of a lower socio-economic status than in middle class males. Other than these three articles, the literature was sparse on the relationship between socioeconomic status and sexual addiction.

Sexual Orientation - Homosexuality/Heterosexuality

The literature, in reference to sexual addiction and homosexuality, often used terms such as “homosexual,” “homosexuality,” and “gay men,” but a common phrase found throughout the literature in reference to gay men was “men who have sex with men,” or “MSM” (Benotsch, Kalichman, & Cage, 2002; Chaney & Blalock, 2006). MSM were often considered to be at risk for online sexual addiction (Benotsch et al., 2002; Chaney & Blalock, 2006). According to the literature, two articles suggested that sexual addiction was more prevalent among gay and bisexual men when compared to heterosexual men (Grov et al., 2008; Grov, Parsons, & Bimbi, 2010). One explanation that was given for this was in relation to gay and bisexual men reporting more lifetime sexual partners compared to other social groups (Grov et al., 2010). Another explanation given was that gay men had a “greater variety of sexual ‘outlets’ (e.g., bathhouses, Internet, sex parties; Parsons, 2005)” (Grov et al., 2010). These factors were believed to make it easier for gay men who were at risk for sexual addiction to have their addictive tendencies triggered and to move down the path to sexual addiction. Cooper et al. (2000) also believed cybersex addiction to be more common with gay and bisexual males than with heterosexual men. Dahlen, Colpitts, and Green (2008) opposed this view, as he believed the majority of American men who struggled with sexual addiction were heterosexual in their sexual orientation. This discrepancy was confusing and raised questions about which perspective was accurate and why they differed.

The literature showed that sexually addicted MSM who accessed Internet chat rooms for sexual purposes were often “in the process of coming out” and likely did not want to be identified as gay (Chaney & Blalock, 2006; Chaney & Chang, 2005; Tikkanen

& Ross, 2000). A significant contributor to sexual addiction among gay and bisexual men was believed to be the “internalization of socially-constructed negative attitudes and myths about gay and bisexual men” (Dew & Chaney, 2005, p. 269). High levels of internalized homophobia were also believed to be correlated with greater frequency to sexual addiction (Dew & Chaney, 2005).

Some of the literature referred to the limitations of the research regarding Internet sexual addiction and homosexuality (Groß et al., 2008). Dew and Chaney (2004) also pointed out that a limited amount of attention had been given to “problems associated with sexual addictions among gay men” (p. 101). Chaney and Chang (2005) also pointed to the limited body of empirical studies that sought to understand the role of the Internet among MSM who were sexually addicted.

The literature advanced a number of explanations for why gay men who demonstrated sexual addiction use the Internet for their sexual expression. Dew and Chaney (2004) pointed to a number of these factors. First, the Internet provided an opportunity to explore one’s sexuality anonymously, and thus prevent judgment. Second, the Internet was used to gather information about gay sexuality that might not normally have been accessible. Third, the literature showed that some gay men used the Internet to meet other men due to the lack of social outlets in their community. Fourth, the Internet provided a place where there was less discrimination regarding one’s physical appearance, allowing users to hide behind an Internet persona. According to Chaney and Dew (2003), the anonymous nature of the Internet allowed people to explore their sexuality “without fear of reprisal from significant others” (p. 260). Online activity also

allowed users to safely obtain information on homosexuality, as well as to communicate with other MSM (Chaney & Dew, 2003), without being judged or persecuted.

The Internet allowed gay men to explore and participate in sexual activities in which they might otherwise never have engaged due to fear (Dew & Chaney, 2004). The anonymity associated with the Internet allowed “self-identified gay men to act out their sexual desires, but also allows men who identify themselves as bisexual or ‘bi-curious’ to use the Internet for sexual gratification” (Dew & Chaney, 2004, pp. 104-105). The Internet allowed married men to experiment and explore their sexuality while remaining discrete in their desire and pursuit of sexual contact rather than taking legal risks by “cruising” parks and public restrooms for sex (Dew & Chaney, 2004).

The literature also pointed to a common occurrence in sexual addiction treatment where male clients who had sex with men often saw themselves as “not gay-identified” (Perry & Barry, 1998). In some cases, according to Perry and Barry (1998), the male clients had primary partners or relationships that were heterosexual, and thus they were living secret lives. There was often a determination not to be identified with the gay community (Perry & Barry, 1998).

Researchers on sexual addiction and sexuality believe there is a strong link between sexual addiction and high-risk sexual behavior among MSM (Benotsch, Kalichman, & Kelly, 1999; Dodge, Reece, Cole, & Sandfort, 2004; Grov et al., 2008; Kalichman et al., 1994; Kalichman & Rompa, 1995, 2001; Kalichman, Greenberg, & Abel, 1997; O’Leary et al., 2005; Parsons, Bimbi, & Halkitis, 2001; Reece, Plate, & Daughtry, 2001). Satinsky et al. (2008) pointed out that “sexual compulsivity has been associated with higher frequencies of sexual behaviors that might increase the risk of

transmission of HIV and other sexually transmitted infections (STI)” (p. 553). Sexually addicted gay men were also less likely to use condoms (Dew & Chaney, 2004; O’Leary et al., 2005), to disclose their HIV to their sexual partners (Grov et al., 2010; Reece, 2003), or to be tested for HIV (Dew & Chaney, 2004). Satinsky et al. (2008) pointed to previous research indicating that men who were sexually addicted and living with HIV were more likely than non-sexually addicted men to report participating in unprotected sexual intercourse with multiple sex partners, participating in frequent unprotected sex acts, engaging in more illicit drug use concurrent with their sexual behavior, and participating in “more unprotected anal and vaginal intercourse with partners of unknown- or HIV-positive sexual health status” (p. 553).

The literature also indicated that gay male teenagers were at a higher risk for the development of sexual addiction. Kort (2004) saw this as a result of the way that gay male sexuality was under regular assault in society, resulting in what he described as “covert cultural sexual abuse” (p. 287). Kort (2004) saw “covert sexual abuse,” such as “verbal abuse aimed at a person or group because of their sexuality and/or gender” (p. 288), as a common experience among gay adolescents. He believed this could easily predispose one to “reenact this trauma through sexually acting out,” (Kort, 2004, p. 287) and might over time result in sexual addiction. Kort (2004) also pointed out that sexually addictive behavior could have been one way that teens masked the difficulties they experienced during adolescence, especially in dealing with the difficulties of being gay. There was not much empirical research related to childhood abuse among Internet sexually addicted MSM (Chaney & Blalock, 2006, p. 112).

Kort (2004) believed gay males as a whole tended to be assaulted and abused as a culture, as well as individually, for their sexuality. According to Kort (2004), these attacks on gay male culture contributed to the individual sexual addiction seen in gay men. Kort (2004) saw this as sexual assault, and addressed the victimization that was brought on by the culture, which demands heterosexuality from males. Niesen (1993) saw heterosexism as a form of this cultural victimization. Dew and Chaney (2005) indicated that “higher levels of internalized homophobia” was connected with greater frequency of sexual addiction (p. 259). Dew and Chaney (2005) also pointed to a greater frequency of sexual compulsivity in gay men, related to the “higher levels of internalized homophobia” (p. 259) they experienced.

Traumatic Experiences in Childhood - Sexual and Physical Abuse

Sexual abuse. The connection between sexual addiction and a history of childhood sexual abuse was quite strong and presented clearly in the literature (Aaron, 2012; Anderson & Coleman, 1991; Carnes, 1991, 2000; Carnes & Delmonico, 2006; Coleman, 1991; Gold & Heffner, 1998; Kort, 2004; Kuzma & Black, 2008; Laaser, 2003; Parsons, Grov, & Golub, 2012; Perera, Reece, Monahan, Billingham, & Finn, 2009; Reid & Woolley, 2006; Rickards & Laaser, 1999; Schneider, 2000; Schwartz, Galperin, & Masters, 1995; Schwartz & Masters, 1994; Schwartz & Southern, 2000; Spiegel, 2008; Tedesco & Bola, 1997). Schneider (2000), in referencing Carnes et al. (1991), stated that sexual addicts were often abused in some manner during their childhood. Rickards and Laaser (1999) indicated that a noteworthy relationship existed between sexual addiction/compulsivity and childhood sexual abuse (see also Carnes, 1991; Anderson & Coleman, 1991; Tedesco & Bola, 1997). Sexual abuse tended to distort the victims’

views on sex, led them to associate shame with sex, and caused many victims to become either hyposexual or hypersexual individuals (Sprenkle, 1987). Giugliano (2006) believed that sexual abuse was also associated with affect dysregulation and compulsive sexual behavior.

Carnes' (1991) study showed that 82% ($n = 233$) of the participants who were sexually addicted reported having a history of childhood sexual abuse. Most of the participants in Carnes' (1991) study reported that their sexual addiction began simultaneously or soon after experiencing childhood abuse, usually around the age of 10 years old. Giugliano (2006) also showed in his study of 14 sexual addicts that 95% of them reported experiencing childhood sexual abuse. Perera, Reece, Monahan, Billingham, and Finn (2009) pointed out that both childhood sexual abuse and a dysfunctional family environment were associated with tendencies towards sexually addictive behavior. Among sexual offenders, sexual addicts were more likely to be victims of childhood sexual abuse than those who were not sexually addicted (Marshall & Marshall, 2006).

In Carnes's (1988) survey of 289 recovering sexual addicts, it was discovered that 81% of the participants reported they had been sexually abused as children. Schwartz and Southern (2000) pointed to another study showing that patients seeking treatment for cybersex addiction, who were heavy users of the Internet for cybersex behavior, were individuals commonly "suffering from the long-term consequences of sexual abuse" (p. 134). Carnes (1991) noted that the majority of the sexual addicts he studied reported some type of abuse or a combination of different forms of abuse (97% [$n = 233$] experienced emotional abuse or neglect, 82% [$n = 233$] experienced sexual abuse, and

72% [$n = 233$] experienced physical abuse). According to Reid and Woolley (2006), sexual addiction was intertwined with sexual abuse, as it could have become a way to escape from the core shame and unhealthy formation of one's identity caused by the childhood trauma. For a sexually abused child, Schneider (1989) believed sex often became greatly confused with and intertwined with nurturing, and this created a problem that persisted throughout one's lifetime. This was a key element, as sexual addiction was not about sex, but more about seeking intimacy, and in this context, "false intimacy."

Abuse and trauma. The literature (Barbieri, 2008; Ellason & Ross, 1999; Whitfield, 1998) expanded the connection between one's sexual addiction and sexual abuse to show how strongly sexual addiction could have been associated with trauma. The literature (Carnes, 1991, 1993; Cox & Howard, 2007; Robinson, 1999; Schwartz, 1992; Tedesco & Bola, 1997; Whitfield, 1998) showed that sexual addiction was believed to have been associated with emotional and physical abuse, as well as trauma. Putnam and Maheu (2000) pointed out that sexual addiction commonly developed as a response to "past physical, sexual, family, and social trauma" (p. 92). Whitfield (1998) noted that research in the field of sexual addiction showed that "all forms of abuse, including sexual abuse," were significant factors in the "genesis of addiction" (p. 270).

Abuse and neglect. According to Sprenkle (1987), child abuse and neglect were common factors in the histories of individuals who manifested hypo/hyper sexuality and sexual addiction. In referring to addiction theory, Sprenkle (1987) suggested that the causes of addiction were often related to two common elements found in the addict's family-of-origin, namely abuse and neglect. He referred to familial abuse and neglect as a type of family intimacy dysfunction (Sprenkle, 1987). In this family atmosphere,

children developed feelings of shame as a result of trauma, and they began to believe they were the cause of the abuse or neglect. According to Sprenkle's (1987) observation, this shame led to low self-esteem and difficulties in interpersonal relationships, thus intensifying their loneliness. The development of addiction began as the child searched for some type of "fix" to alleviate the psychological pain (Sprenkle, 1987).

Abuse and emotional dysregulation. A history of abuse and neglect, and the resulting difficulty of affect regulation, set up many of these victims for a life of sexual addiction. Many abused and neglected children learned that they could regulate their affect and internal states through compulsive sexual behavior, among other forms of problematic conduct (Giugliano, 2006). According to Giugliano (2006), sexual addiction was commonly used as a way to "escape painful or dysphoric feelings" (p. 367), as well as to help to regulate the emotional life of the addict and manage stress (see also Carnes, 2000).

Schwartz and Southern (1999), pointed out that abused or neglected children often experienced or anticipated "abandonment, unfairness, or conflict with caretakers, which leads to powerful feelings of rage, anxiety, and helplessness" (p. 170). These feelings could have been quite dangerous, given these children's dependence on their caretakers for survival, for they would have taken a great risk if they had shown these emotions or spoken about how they were affected. They risked further invalidation or abandonment if they spoke about these issues, for their caretaker might have just "walked away" without acknowledging them. Their security and their world revolved around their caretakers. This family-of-origin experience was thought to be a prime setup for sexual addiction (Schwartz & Southern, 1999). When they experienced difficulty later in life, it could

have caused suppressed feelings of rage, anxiety, and helplessness to resurface, thus triggering the need to engage in some type of behavior that would reduce the tension and help to regulate their affect. This was often accomplished through sexually compulsive behavior (Schwartz & Southern, 1999). This could often have developed into sexually (or other) addictive behavior over time and led to a repetition of the behavior and the strengthening of the addictive cycle as one continued to regulate one's affect through these addictive means.

Reenacting traumatic abuse through cybersex participation. A few articles in the literature pointed to the notion of sexual addicts recreating and reenacting traumatic abuse and previously experienced patterns of attachment through their sexually addicted behavior (Carnes, 2000; Ellason & Ross, 1999; Giugliano, 2006; Kort, 2004; Schwartz, 1996; Schwartz & Masters, 1994; Whitfield, 1998). Different theories and ideas were proposed to explain this pattern, mainly from a psychodynamic point of view. According to Adams and Robinson (2001), this helped to explain why sexual addicts might have made destructive relational choices. Schwartz and Southern (2000) pointed out that dissociation became a survival strategy that children developed to handle contrary experiences, such as enduring abuse at home, while at the same time maintaining the ability to function in school and outside the home. Dissociation helped the sexual addict to forget traumatic and disturbing childhood experiences (Schwartz & Southern, 2000). Schwartz and Southern (2000) believed that these dissociated experiences “leak into [the] consciousness as reenactments” both sexually and relationally (p. 130). With this in mind, Schwartz and Southern (2000) believed that compulsive cybersex participants (i.e., those who engaged in sexual behavior predominately or exclusively online), when acting

out sexually online, experienced “dissociative reenactments of past conflicts or traumas with an underlying motive to resolve unfinished business” (p. 130). According to Schwartz (1996), reenactments were expressions of unresolved trauma that were ritualized and used to gain mastery over unresolved issues.

The sexual addict’s compulsive cybersex behavior was believed to also be “a primary or exclusive means of sexual outlet in which the survivor of childhood trauma encapsulates the overwhelming pain and shame of the past, reenacts salient features of the original events, and copes with the increasingly burdensome demands of selfhood in daily life” (Schwartz & Southern, 2000, p. 130-131). The literature primarily pointed to cybersex, but the reenactment of traumatic abuse was applicable to many other areas of sexually addictive behavior.

The Internet presented the “perfect” environment for reenacting abuse. The sexual addict had immediate access on the Internet to a surplus of anonymous, role-playing partners, as well as a wide range of sexual interests (Schwartz & Southern, 2000). One could easily have entered into a world of fantasy that allowed one to explore or reenact past traumatic abuse. Schwartz and Southern (2000) saw compulsive cybersex as a likely way that the “ego state has evolved to reenact unfinished business, while the executive self-parents, goes to work, or otherwise maintains a normal lifestyle” (p. 130). A certain “splitting” behavior was believed to happen in order to allow the addict to “function” in the real world and feel a sense of control in working through unresolved trauma of the past.

The literature also described compulsive cybersex behavior and addiction as a way to reenact past trauma and pain in order to promote feelings of power and love

(Schwartz & Southern, 2000). Sexually addictive behavior could have given sexual addicts a sense of revenge and an illusion of mastery over what was once beyond their control. Repetitively reenacting the original trauma could have helped them feel like they were in control of what was once out of their control (Giugliano, 2003). It might also have reiterated the original lesson they learned during their past sexual trauma – that the only way they would have experienced any type of closeness, intimacy, or perceived “love” was through sex (Giugliano, 2003). Because of this, they continued to go back to the same sexual behavior in order to experience “intimacy” and “love.”

Compulsive cybersex behavior could have also helped the addict escape memories of abuse and become a distraction from the shame, self-contempt, and other resulting emotions and thoughts that had become an encumbrance. It was believed to also help “soothe” the pain and allow sexual addicts to “escape” from their past experiences and issues related to their family-of-origin (Schwartz & Southern, 2000). Compulsive cybersex became a way to compensate for low self-esteem and to restore self-worth. It became a temporary relief and “fix” to anesthetize one’s psychological pain (Giugliano, 2003). These anesthetizing agents only provided temporary relief, and the feelings of shame, despair, loneliness, and low self-esteem quickly returned, thus tempting the addict back to another “fix.” This was where the cycle of sexual addiction began.

The desire to be wanted by another person was an essential part of the fantasy of a cybersex abuser (Schwartz & Southern, 2000). Cybersex addicts longed to be wanted and desired, but they hid behind “false identities and ritualized role play” (Schwartz & Southern, 2000, p. 131). Cybersex allowed them to feel intimate and close, while

maintaining a safe distance with an anonymous partner in another part of the world. The result was an intimacy disorder that was self-perpetuating. The cybersex actions of such addicts helped them to feel “connected,” while keeping them “safe” from emotional pain (Schwartz & Southern, 2000). They developed a “false intimacy” that seemed to satisfy their need for intimacy, but within a short period of time, it was exposed for the truth of what it was and the addict began to feel even greater emptiness and lack of connection. The sexual connection that the cybersex addict made with others was illusory, but for a period of time it helped them to escape loneliness, boredom, and the deep emptiness within (Schwartz & Southern, 2000).

Conclusion

The results of this comprehensive literature review showed limited research at points on this topic. A number of the articles expressed viewpoints and theories that were specific to the subject matter at hand. More research needed to be conducted on the dynamics of the family-of-origin of men who were sexually addicted and how these factors might have related to the development of sexual addiction. The main themes discovered throughout the literature were the common factors in the origin of sexual addiction and the relationship between childhood trauma and neglect. Invalidation by the addict’s family-of-origin, the core beliefs of sexual addicts learned in childhood, and the impact of shame experienced in their families-of-origin were other major themes found throughout the literature.

Most theorists believed that family-of-origin characteristics impacted sexual addiction, but the empirical validation for these views was quite limited. More research with empirical validation was needed on the impact of family-of-origin characteristics on

sexual addiction. More research and understanding of these dynamics and their influence on sexual addiction would better equip sexual addiction therapists to understand the complexities of the disorder and to develop better techniques for treating sexual addiction.

CHAPTER III

METHODOLOGY

The purpose of this study was to determine whether there were any consistent demographic or family-of-origin characteristics in men who engaged regularly with sexually addictive behavior. Based on the literature review findings, it was predicted that men who were involved in sexually addictive behavior would more often come from a family-of-origin that was extreme on a number of factors. This chapter details the research design and methodology that was used to gather information and to analyze the results of this study. This chapter outlines the measures and procedures used to identify family-of-origin characteristics in participants who regularly engaged in sexually addictive behavior, as well as the pertinent demographic variables. Demographic factors, including age, ethnicity/race, relational status, educational background, socioeconomic status, history of sexual abuse, and sexual orientation were examined to see if there was a relationship with sexually addictive behavior. The population and procedure used to obtain a sample of participants were described, and the criterion and predictor variables were defined. Finally, both instruments used in the study, the Sexual Addiction Screening Test (*SAST*) and the Family Sexuality Scale (*FSS*), are described and explained.

Research Design

Descriptive research methodology was used to identify family-of-origin characteristics in men with sexually addictive behavior. The method was selected in order to help “describe systematically, factually, and accurately” the phenomenon (Roberts, 2004, p. 149). The correlational research design for this study determined the

degree to which the criterion and predictor variables had an association. The criterion variable was sexually addictive behavior. Initially there were four predictor variables in this study: communication openness in one's family-of-origin regarding sexuality; derogatory/negative communication in one's family-of-origin regarding sexuality; exposure to sexual stimuli; and age-inappropriateness of sexual communication in one's family-of-origin. Additionally, there were a number of demographic predictor variables: age, ethnicity/race, relational status, educational background, socioeconomic status, sexual orientation, and history of sexual abuse.

Data collection was accomplished by a self-report survey. Two survey instruments, the Sexual Addiction Screening Test (*SAST*, Carnes, 1989) and the Family Sexuality Scale (*FSS*, Pfuetze & Cottone, 2013), were given to each participant, along with the demographic questionnaire. The sample for this study was a convenience sample (non-probability sample), thus the study might unintentionally exclude a portion of the population of sexually addictive men. In this particular research, the criterion variable was sexually addictive behavior, which was measured using the *SAST*. The *SAST* was correlated with scores from the *FSS*. The predictor variables were measured using the *FSS*.

Hypotheses and Research Question

The initial hypotheses and research question of this study were as follows:

Research Question

Is there a relationship between demographic variables (including (a) age, (b) ethnicity/race, (c) relational status, (d) educational background, (e) socioeconomic status, (f) sexual orientation, and (g) history of sexual abuse) or family factors (including (a)

communication openness, (b) derogatory and negative communication, (c) exposure to sexual stimuli, and (d) age-inappropriate sexual communication) and sexual addiction?

Hypotheses

Hypothesis I. Higher levels of negative attitudes about sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction.

Hypothesis II. Higher levels of derogatory/negative communication regarding sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction.

Hypothesis III. Higher levels of exposure to sexual stimuli in one's family-of-origin would correlate positively to a measure of sexual addiction.

Hypothesis IV. Less open sexual discussion in one's family-of-origin would correlate positively to a measure of sexual addiction.

This study examined data for any correlations that existed between a man's sexually addictive behavior and how his family-of-origin addressed sexuality. The hypotheses for this study were directional, as the literature indicated that certain family-of-origin characteristics were related to and influenced sexually addictive behavior in adulthood.

Participants

Informed consent was obtained from males who self-reported that they were at least 18 years of age at the time of participation. Participants who were under the age of 18 were not allowed to participate in the research. Initially 32 male participants from a graduate school class participated in a test-retest reliability analysis of the Family Sexuality Scale (*FSS*). For the full study, to ensure a diverse sample, participants were

recruited through local men's groups and through the Internet upon approval from the Institutional Review Board (IRB) of the University of Missouri-St. Louis. Convenience sampling (non-probability sampling) was used to select the sample. Approximately 227 participants were needed to obtain statistical significance at an alpha level of .01 and a power level of .95 with a medium effect size according to the statistical software G*Power 3.1.5 (Faul, 2009).

The demographics of the individuals who participated in the research were described below. These demographics included age, ethnicity/race, relational status, educational background, socioeconomic status, sexual orientation, and history of sexual abuse. A total of 521 individuals began the online survey, which was located on SurveyMonkey. One hundred forty-seven individuals were eliminated from the data analysis for not finishing one or both scales, or for indicating they were female. A total of 374 participants provided complete data sets via the online survey. Descriptive statistics were computed for the demographic variables of the total sample (see Table 2).

The participants ranged from 20 to 76 years of age ($M = 39.6$ years; $SD = 11.6$) with the majority of participants being in the age range of 25-45 years old. Participants in this sample were overwhelming White ($n = 344$; 92%). The majority of participants reported their relational status as Married/Partnered ($n = 304$; 81.3%). The largest group of participants had a Graduate or Professional Degree ($n = 185$; 49.5%). The majority of participants indicated their socioeconomic status/annual household income level was \$100,000 and above ($n = 99$; 26.5%). Three different questions were utilized to explore the participants' sexual orientation. These questions focused on their sexual behavior, their sexual attraction, and how they identified themselves sexually. The majority of

participants defined their sexual activity or behavior as “all sex with opposite sex” ($n = 286$; 76.5%), their sexual attraction as “totally attracted to opposite sex” ($n = 290$; 77.5%), and their sexual orientation as heterosexual ($n = 347$; 92.8%), with gay being the second largest group of participants ($n = 17$; 4.5%). The majority of participants indicated they had not been sexually abused as a child or adolescent ($n = 291$; 78.0%). Eighty-two participants (22.0%) indicated they had been sexually abused as a child or adolescent.

Measures

Sexual Addiction Screening Test (SAST) (Carnes, 1989)

Overview. The *SAST* was designed to assist in the assessment of sexually compulsive behavior, which may indicate the presence of sexual addiction (Carnes, 1989). The *SAST* has been used in many different settings including criminal justice systems, treatment facilities, and educational programs (Hueppelheuser, Crawford & George, 1997; Spickard, Swiggart, Manley & Dodd, 2002; Weiss, 2004). The *SAST* distinguishes males who are non-sexual addicts from those males who are addicted to sex. The *SAST* is a subjective, self-completed report that is “widely used in clinical practice” (Hook et al., 2010, p. 246). The measure usually takes about 15 minutes to complete. The *SAST* consists of 25 forced “Yes” or “No” questions that measures sexual addiction symptoms. Scoring for the test was based on the total score of all questions answered in the affirmative (“Yes”). Total scores range from 0 to 25, with a higher score reflecting a greater level of sexual addiction. A copy of the *SAST* is included in Appendix C.

***SAST* Reliability and Validity.** Carnes’s (1989) study involved 191 sexually

addicted men and 67 sexually non-addicted men. Reliability for the *SAST* survey (Cronbach's alpha) was 0.95 for the total sample, 0.92 for the sexually addicted men, and 0.85 for the sexually non-addicted men. Internal consistency (Cronbach's alpha) of the *SAST* ranged from 0.89 to 0.95 in four samples (Carnes, 1989) showing strong psychometric support for the *SAST* (Carnes et al., 2010). Temporal stability for the *SAST* had not been reported according to Hook, Davis, Worthington, Jr., and Penberthy (2010).

The scoring of the *SAST* put participants into one of three categories: "not at-risk," "at-risk," and "in need of treatment." Scores between 0-10 put a participant in the "not at-risk" category. A participant with a score of 11 or 12 was considered "at-risk." Scores of 13 or higher put the participant in the category of "in need of treatment." According to Carnes (1989), a score of 13 or higher suggested the presence of sexual addiction. When 13 was used as the cutoff score, "96.5% of respondents were correctly classified as sexually addicted" (Carnes, 1989, p. 222). Only 3.5% of those who scored 13 or more were non-addicted, and thus were misclassified using the *SAST* (Carnes, 1989). The *SAST* was shown to effectively and efficiently discriminate between sexual addicts and nonaddicts (Carnes et al., 2010), as well as between male sexual addicts and male control populations. Furthermore, participants identified as having a sexual addiction scored higher on the *SAST* than those who did not (Carnes, 1989).

Convergent validity was evident with the *SAST*, as it correlated with measures of sexual addiction (Delmonico, Bubenzer, & West, 1998; Delmonico & Miller, 2003; Garos & Stock, 1998b), depression, anxiety, alcohol/drug dependence (Nelson & Oehlert, 2008), boundary violations (Swiggart, Feurer, Samenow, Delmonico, & Spickard, 2008), and insecure attachment (Zapf, Greiner, & Carroll, 2008). The *SAST* has been correlated

with the *Sexual Dependency Inventory – Revised*, the *Garos Sexual Behavior Index*, and the *Internet Sex Screening Test* (Zapf et al., 2008). The *SAST* has also been shown to have evidence for discriminant validity, as it was unrelated to measures of social desirability and intelligence (Nelson & Oehlert, 2008). In regard to criterion-related validity, the sexual addiction group scored higher on the *SAST* than the comparison group (Swiggart, Feurer, Samenow, Delmonico, & Spickard, 2008).

The Family Sexuality Scale (*FSS*)

Since there were no instruments available to measure how one's family-of-origin handled the issue and topic of sexuality, an instrument was developed for this study. The *FSS* is a Likert-type scale consisting of a number of items that target how one's family-of-origin handled sexuality. A copy of the *FSS* was placed in Appendix D.

The *FSS* initially consisted of four sections: negative attitudes about sexuality in one's family-of-origin, derogatory/negative communication regarding sexuality in one's family-of-origin, exposure to sexual stimuli in one's family-of-origin, and open sexual discussion in one's family-of-origin. The original four variables each contained a number of items that together formed the final number of items for the whole scale.

The *FSS* is a newly developed scale specific to this study. Because of this, limited data were available regarding the scale. A test/retest reliability procedure was first performed on the *FSS*. The test-retest reliability assessed the degree to which the test scores were consistent from the first test to the retest on each subscale. The correlations between the two scores assessed the reliability of the test. If the reliability coefficient were below 0.7, then the *FSS* would have been revised to ensure adequate reliability before the final study. If revision were needed, certain items would have been

revised, added, or eliminated in order to improve the reliability coefficient. If the deletions of certain items were the only revisions made, then a new analysis would have been performed on the *FSS* to ensure the reliability coefficient met the minimum requirement (0.7) for adequate reliability. If new items were added then a new test/retest reliability procedure would have taken place to ensure that the reliability coefficient met the minimal level of adequate reliability (0.7).

A factor analysis was performed on the data that were accumulated after the main study was completed. Factor analysis was used to estimate the connections between factors and the observed variables. It was assumed that four factors would emerge statistically, corresponding to the design of the four subscales of the *FSS*. The hypotheses might have needed to be revised depending on the factors, and corresponding to the factors, derived from the factor analysis.

Items on the *FSS* were constructed according to the following procedures. The item stimulus consisted of a statement describing events, situations, and/or behaviors that one might have experienced in one's family-of-origin. Item responses were listed on a Likert-type scale from 1 (strongly disagree) to 6 (strongly agree). Each participant was instructed to choose the response they felt best fit their experience in their family-of-origin. Half of the items were written in positive form (higher score indicating a problem) and half written in negative form (lower score indicating a problem) to prevent a response bias.

In order to establish content validity, a panel of three experts in sexual addiction and one expert in marriage and family therapy were consulted about the initial pool of 64 items. The final panel of four experts chosen to participate in the content validity portion

of the study were all male. Each of the experts had doctoral degrees. One of the experts was a Certified Clinical Sexual Addiction Specialist, while another was the current Editor-in-Chief of the journal *Sexual Addiction & Compulsivity*. Three of the experts were professors in graduate counseling programs; one was a national speaker on sexual addiction issues; and all four were involved in private counseling practices. The four experts reported an average of 30 years of clinical counseling experience, an average of 20 years of teaching on a graduate level, and an average of 20 years of working in the area of sexual addiction.

The panel of experts received a short summary of the purpose of the study, a draft copy of the *FSS*, and brief descriptions of the types of family-of-origin being described. The experts made recommendations related to the items' appropriateness, situations addressed, clarity of expression, and instructions given. Feedback from the experts played an important role in deciding which items to include, exclude, and revise.

Procedures

The online survey software SurveyMonkey was used to create the online surveys. Upon accessing the surveys online, each potential participant, i.e. males who self-reported that they were eighteen years of age and older at the time of participation, were first presented with an informed consent form. This form described the nature of the research as well as what the subject's participation would entail. This allowed each subject to voluntarily choose whether they would participate in the study or not. Each subject was informed that they did not have to participate in the study or could back out at anytime during the process. Participants were also informed of any potential effects, both positive and negative, that might occur during the process. Due to the minimal

psychological risk each participant might have experienced, a list of counseling referrals was given to each student at the end of the study. After reading the informed consent page and agreeing to the informed consent requirements, adult participants were then directed to the demographic questionnaire (see Appendix A), the Family Sexuality Scale (*FSS*) (Pfuetze & Cottone, 2013) (see Appendix B), and the Sexual Addiction Screening Test (*SAST*) (Carnes, 1989) (see Appendix C). Data collection was accomplished by a self-report survey using the *FSS*, *SAST*, and demographic questionnaire. The demographic questionnaire (Appendix A) asked about the participant's age, ethnicity/race, relational status, educational background, socioeconomic/annual household income levels, a history of sexual abuse (yes/no), and sexual orientation.

The surveys did not ask for participants' names or other identifying information in order to keep the participants anonymous. The surveys took between 20-30 minutes to complete. Prior to the study being conducted, the procedures for the study were submitted to the Institutional Review Board for approval. Participants accessed the online survey through listservs and Facebook. A Facebook page was set up in order to contact and gather participants. Participants who accessed the Facebook page were not allowed to post comments or anything that might reveal their identity. There was a link from the Facebook page to the study, the informed consent form, and the measures. A number of specific listservs that were applicable to the study also had a link to the description of the study, the informed consent form, and the measures. Listservs specific to the gay male community were also used. Different groups that were applicable to the study, such as Sexual Addiction groups, were contacted in order to invite group members

to access the online surveys and participate in the research. Special consideration was given to protect the confidentiality of participants.

Analysis

The researcher minimized threats to internal validity, external validity, conclusion validity, and construct validity. To minimize these specific threats, conditions were avoided that created error variance in relation to statistical conclusion validity, such as not having sufficient power, using unreliable measures, and using a heterogeneous sample instead of a homogeneous sample. Threats to external validity were minimized by the use of general findings to representative groups. Threats to construct validity were minimized through the review of questions from the *FSS* by experts in the field of sexual addiction and family therapy. In an effort to reduce threats to construct validity, careful measures were taken to select representative criterion and predictor variables.

This study was a correlational assessment of self-report surveys. Heppner, Kivlighan, Jr., and Wampold (1999) pointed out that “correlational designs cannot enable the researcher to identify causal relationships” (p. 412). There would be no way to prove or determine causation between variables from a correlational study. This type of study only determined whether or not two variables were associated. Correlational studies examined whether an increase or decrease in one variable corresponded to another variable’s increase or decrease.

To analyze whether there was a relationship between a man’s sexually addictive behavior and how his family-of-origin handled sexuality, the researcher used correlation analysis. Correlation analysis was a statistical method for studying and describing the linear association between two variables and the strength of the relationship. The

correlation coefficient was the measure of the linear association between the two variables. The value of the correlation coefficient was always between -1 and +1, with a value of 0.00 indicating there was no relationship.

Correlational analysis was performed with the *FSS-R* subscales and *SAST* scores. The results could not be interpreted as establishing a cause-and-effect relationship. They only indicated how or to what extent variables were associated with each other. The correlation coefficient showed the degree of linear association between the two variables. The correlational coefficient provided an index of the degree of relationship between the criterion and predictor variable.

Level of Significance

Type I error, known as an alpha error, is when one rejects the null hypothesis despite the fact that it is true. Type II error, known as a beta error, is made when one retains the null hypothesis, even though it is false. This research controlled for these errors through the use of significance testing, with the alpha level being 0.01. This level was set conservatively based on the use of new instrumentation, the exploratory nature of this research, and the majority of the research in this field of study set an alpha level of 0.01.

Demographic Findings

Descriptive statistics were used to organize and summarize the research data and to present quantitative descriptions in a manageable form. Specifically, participants were described by age, ethnicity/race, relational status, educational background, socioeconomic status, history of sexual abuse, and sexual orientation.

Summary

This study examined whether there were any predictable demographic or family-of-origin characteristics in men who engaged regularly with sexually addictive behavior. The participants were invited to participate by email, through the Internet, and through personal engagement. Once subjects consented to participate, they were asked to complete the *Sexual Addiction Screening Test (SAST)*, which measured sexually addictive behavior, and the *Family Sexuality Scale - Revised (FSS-R)*, which measured how one's family-of-origin handled the issue and topic of sexuality. They were also asked to complete demographic measures. Participation was voluntary and approximately 20-30 minutes were necessary to complete all measures.

Because there was much anecdotal evidence and limited research related to the impact of family-of-origin on male sexually addictive behavior, it was important to conduct a study that sought to better understand the potential effects of how one's family-of-origin handled sexuality in the home during one's childhood. This study might provide insight into how the handling of sexuality in the home by one's family-of-origin related to sexually addictive behavior. Having this information could help mental health professionals and developmental psychologists to formulate possible methods of prevention of sexual addiction later in life. This information could also benefit parents by helping them understand the impact of how they handle sexuality in the home as they rear their children.

CHAPTER IV

RESULTS

Introduction

This study examined family-of-origin characteristics surrounding the sexuality of men who regularly engaged in sexually addictive behavior. The purpose of this study was to determine whether there were any consistent family-of-origin characteristics in men who engaged regularly in sexually addictive behavior, as well as to discover whether there were any associations between sexual addiction and specific demographic factors. There was much theory and anecdotal evidence from therapists who worked in the area of sexual addiction (along with a limited body of literature) that indicated men who engaged in sexually addictive behaviors shared certain common factors in their family-of-origin histories.

This chapter is organized into six sections. The first section describes the demographics for this study and its relationship with sexual addiction. The second section outlines the test-retest reliability procedure that was performed on the Family Sexuality Scale (*FSS*). The third section outlines the factor analysis procedure that was performed on the data accumulated after the main study was completed. The factor analysis helped to explain connections that were made between certain factors and the observed variables. The fourth section outlines the revised version of the *FSS* based upon factor analysis. A test-retest reliability procedure was then performed on the revised Family Sexuality Scale (*FSS-R*). The fifth section outlines and describes the three constructs from the *FSS-R* followed by hypothesis testing. The final section summarizes the results of this study.

Demographics and Sexual Addiction

This study explored the relationship between sexual addiction and certain demographic variables. The demographics addressed in this study included age, ethnicity/race, relational status, educational background, socioeconomic status, sexual orientation, and history of sexual abuse. The literature showed that sexual orientation (Groves et al., 2008; Missildine et al., 2005) and sexual abuse (Parsons, Groves, & Golub, 2012; see also Aaron, 2012; Anderson & Coleman, 1991; Carnes, 1991, 2000; Carnes & Delmonico, 2006; Coleman, 1991; Cox & Howard, 2007; Laaser, 2003; Rickards & Laaser, 1999; Schneider, 2000) were associated with sexual addiction. According to the literature, certain demographic factors such as race (Giugliano, 2003, 2008; Ragan & Martin, 2000; Robinson, 1999), relational status (Daneback et al., 2006; Cooper et al., 2000a; Cooper et al., 2000b), and socioeconomic status (Carnes, 1989; Marshall et al., 2008; Marshall & Marshall, 2010) have a possible association with sexual addiction. These were all based on hypotheses, as no quantitative data were available.

Sexual Orientation

In this study, each participant was asked about his sexual orientation. Three different questions were asked to explore the participants' sexual orientation from three different perspectives. These perspectives included their sexual behavior, their sexual attraction, and how they identified themselves sexually.

Sexual activity/behavior. The participants' sexual behavior was assessed by the question, "How would you define your sexual activity or behavior?" There were eight options available for participants answering this question (see Table 2). Two categories, "all sex with the opposite sex" and "all sex with the same sex," accounted for 86.7% of

the participants. The next highest category included those who “never had sex.” In light of this, the top three categories accounted for 92.6% of the participants. The remaining categories (7.4 %) were in the middle of the spectrum, where participants reported sexual behavior that was oriented toward both sexes to some degree.

Sexual orientation with respect to sexual activity/behavior was compared to one’s total score on the *SAST*. To assess whether there was a significant relationship between the demographic Sexual Activity/Behavior and *SAST* Total Score, participants were grouped in terms of four categories, Heterosexual ($M = 10.19, SD = 13.1, N = 300$), Bisexual ($M = 17.36, SD = 3.36, N = 11$), Gay ($M = 10.24, SD = 5.84, N = 41$), and Never Had Sex ($M = 11.09, SD = 4.32, N = 22$). A one-way between-groups ANOVA was conducted. The one-way between-groups ANOVA revealed a statistically significant relationship between Sexual Activity/Behavior and the *SAST* Total Score ($F_{3,370} = 6.10, p < .0001$). The post hoc comparison (Tukey) demonstrated significant differences between Bisexual and Heterosexual ($p < .001$), Bisexual and Gay ($p = .001$), and Bisexual and Never Had Sex ($p = .012$). Bisexual participants’ scored higher on the *SAST* than participants in the Heterosexual, Gay, and Never Had Sex categories. .

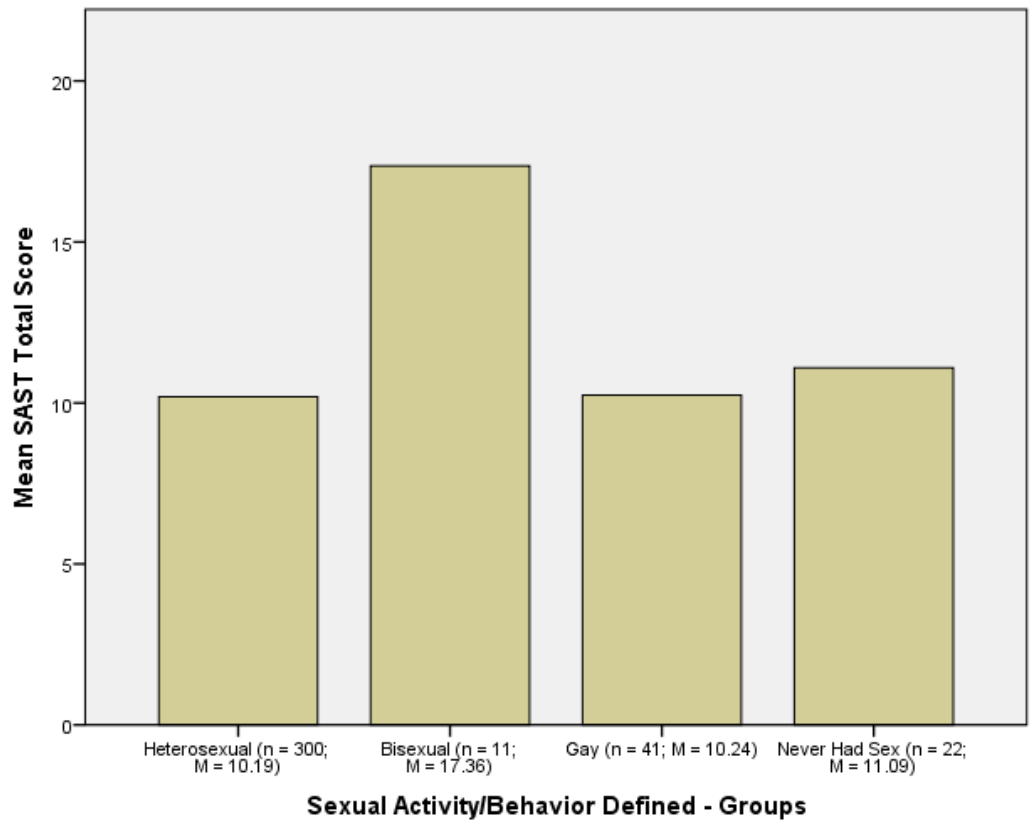


Figure 1. Sexual activity/behavior defined and *SAST* mean total score

According to Carnes (1989) a score of 13 or higher on the *SAST* indicated that the test taker might be sexually addicted (see also Carnes et al., 2010). In this study, 151 participants (40.4%) scored 13 or above and 223 (59.6%) scored below 13 on the *SAST*.

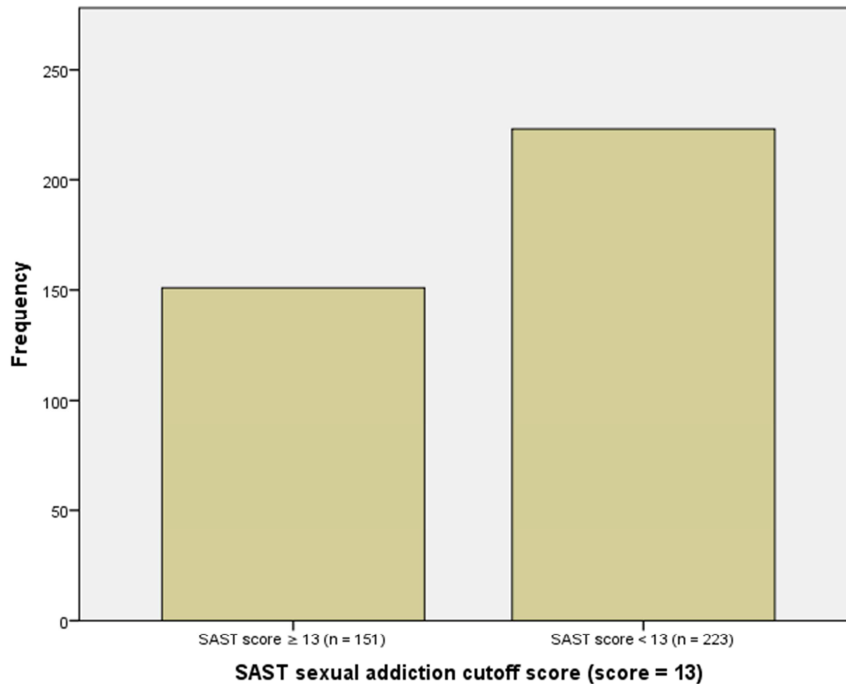


Figure 2. *SAST* sexual addiction cutoff score (score = 13)

All of the participants who identified their sexual activity as “equal with both sexes” ($n = 1$, 100%), “more sex with same sex” ($n = 4$, 100%), and “mostly sex with same sex” ($n = 3$, 100%) scored above 13 on the *SAST* indicating sexual addiction. The next highest category was “more sex with opposite sex” where 83% ($n = 5$) of the participants indicated they were sexually addicted as they scored above 13 on the *SAST*. Close to half of “mostly sex with opposite sex” participants ($n = 8$, 49%) scored above 13 on the *SAST*. The two lowest percentages of groups scoring above 13 on the *SAST* were all sex with opposite sex ($n = 109$, 38.2%) and all sex with same sex ($n = 13$, 39%). The categories that had the highest percentage of participants scoring above 13 tended to be located in the middle of the spectrum where sexual activity was with both sexes. The

lowest percentages were found with those participants on the ends of the spectrum where sexual activity took place with one sex not both.

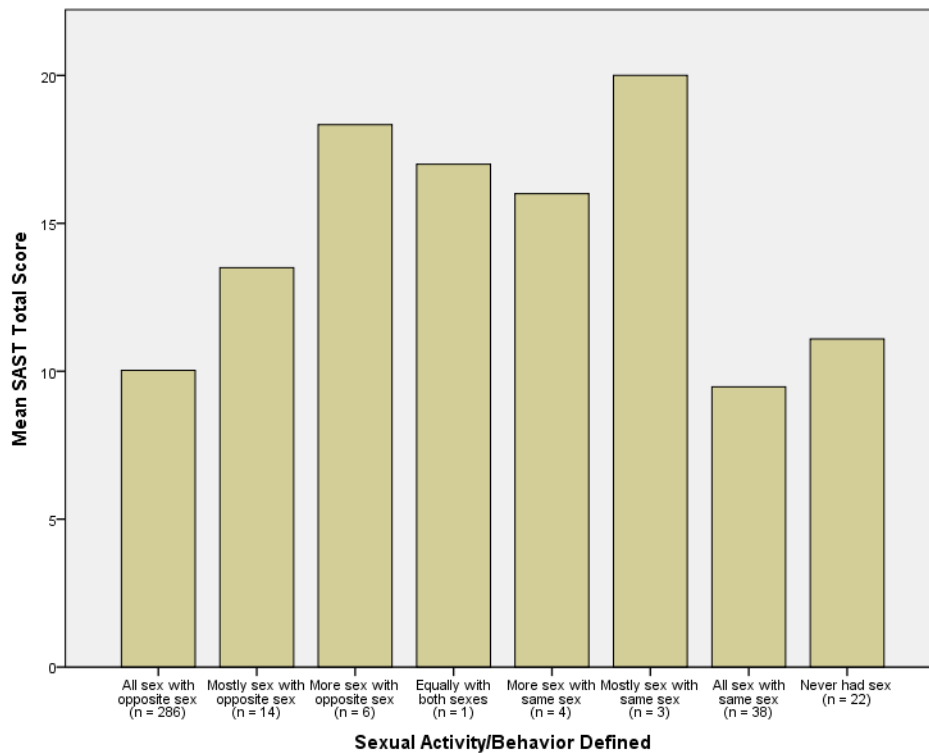


Figure 3. Sexual activity/behavior defined (eight categories) and *SAST* mean total score

Sexual attraction. Similar to the question about sexual activity, the first two categories, “totally attracted to the opposite sex” and “totally attracted to the same sex”, accounted for 86.9% ($n = 325$) of the participants (see Table 2). The next two categories, “mostly attracted to the opposite sex” and “mostly attracted to the same sex”, accounted for 8.8% ($n = 33$) of the participants. The top four categories, totally attracted to the opposite sex, totally attracted to the same sex, mostly attracted to the opposite sex, and mostly attracted to the same sex, accounted for 95.7% ($n = 358$) of the participants, revealing that the participants primarily indicated attraction to one sex or the other. The last three groups included those who were more attracted to both sexes, i.e. “more

attracted to the opposite sex”, “more attracted to the same sex”, and “equally attracted to both sexes”. The remaining three categories ($n = 15, 4.0\%$) emerged in the middle of the spectrum, reporting sexual attraction to both sexes to some degree.

Sexual orientation with respect to sexual attraction was compared to one’s total score on the *SAST*. To assess whether there was a significant relationship between the demographic Sexual Attraction and *SAST* Total Score, participants were grouped in terms of three categories, Gay ($M = 10.14, SD = 5.83, N = 35$), Bisexual ($M = 12.35, SD = 6.63, N = 48$), and Heterosexual ($M = 10.20, SD = 5.38, N = 290$). Participants that indicated they were totally attracted to the same sex were grouped under the Gay category. Those who indicated they were totally attracted to the opposite sex were grouped under the Heterosexual category. The remaining participants were grouped under the Bisexual category. A one-way between-groups ANOVA was conducted. The one-way between-groups ANOVA indicated there was a significant relationship between Sexual Attraction and the *SAST* Total Score ($F_{2,370} = 3.12, p = .045$). The Tukey post hoc analysis revealed that the Bisexual participants ($n = 48$) had significantly higher scores than the Heterosexual participants ($p = .04$). There was no significant difference between Gay and Bisexual participants.

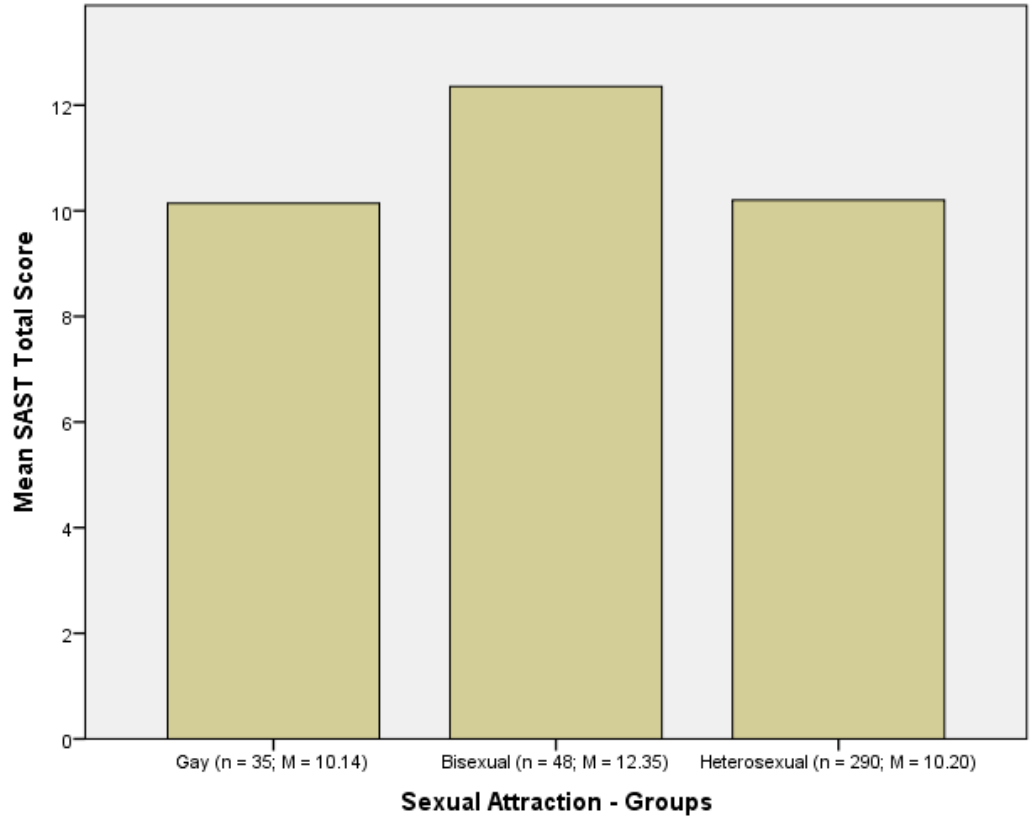


Figure 4. Sexual attraction (three categories) and *SAST* mean total score

All of the participants in the more attracted to same sex category ($n = 5$; 100%) and 68% ($n = 4$) of those in the more attracted to opposite sex category scored above 13 on the *SAST* indicating a real possibility of sexual addiction. Both of these were located on the middle of the spectrum, indicating that sexual attraction was more towards both sexes. Both of the categories, mostly attracted to opposite sex ($n = 12$) and equal between both sexes ($n = 2$), showed 50% of their participants scoring above the sexual addiction threshold of 13 points on the *SAST*. Both of the categories, totally attracted to same sex ($n = 35$) and totally attracted to opposite sex ($n = 290$), showed close to 40% of their participants scoring above the sexual addiction threshold of 13 points on the *SAST*.

The mostly attracted to same sex category had a significantly lower number of participants scoring above 13 than the other categories ($n = 2$, 20%).

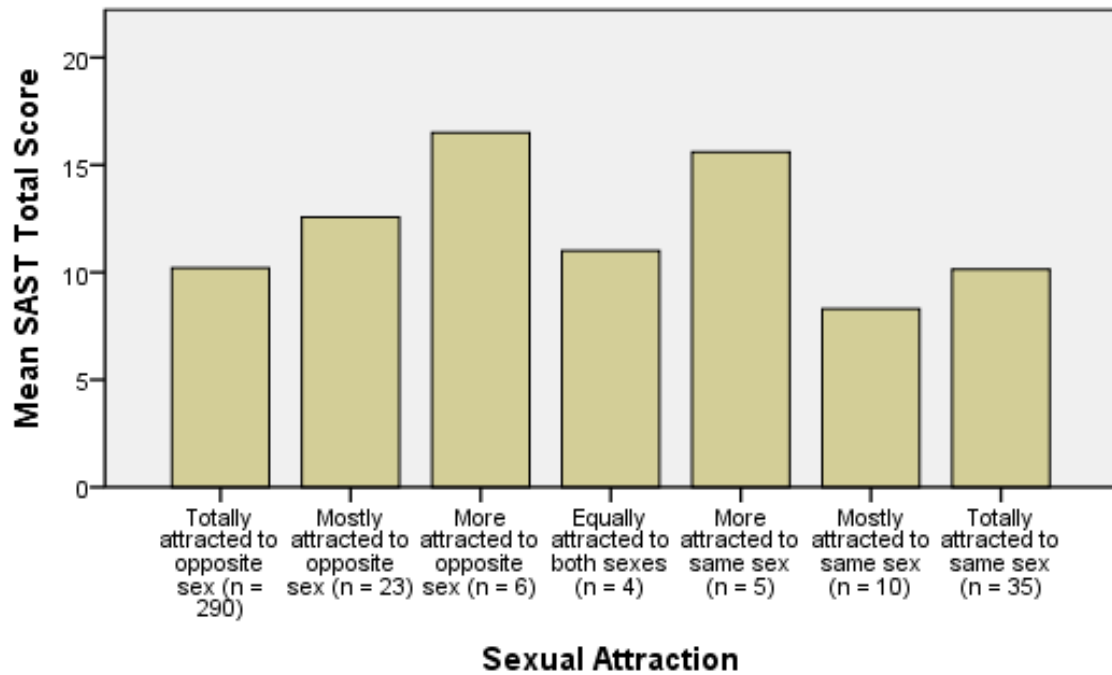


Figure 5. Sexual attraction and *SAST* mean total score

Self-described sexual orientation. The options under the third question, “How would you define your sexual orientation?” included Heterosexual, Gay, Bisexual, and Other (please specify) (see Table 2). The majority of participants reported that they were heterosexual, with smaller samples having reported that they were gay or bisexual. Self-described sexual orientation was compared to one’s total score on the *SAST*. To assess whether there was a significant relationship between the demographic Self-described Sexual Orientation and *SAST* Total Score, participants were grouped into two groups, Heterosexual ($M = 10.48$, $SD = 5.61$, $N = 347$) and non-Heterosexual ($M = 10.15$, $SD =$

6.03, $N = 26$). A one-way between-groups ANOVA was conducted. The one-way between-groups ANOVA indicated there was no significant difference between sexual orientation groups on the *SAST* Total Score ($F_{1,371} = .08, p = .78$).

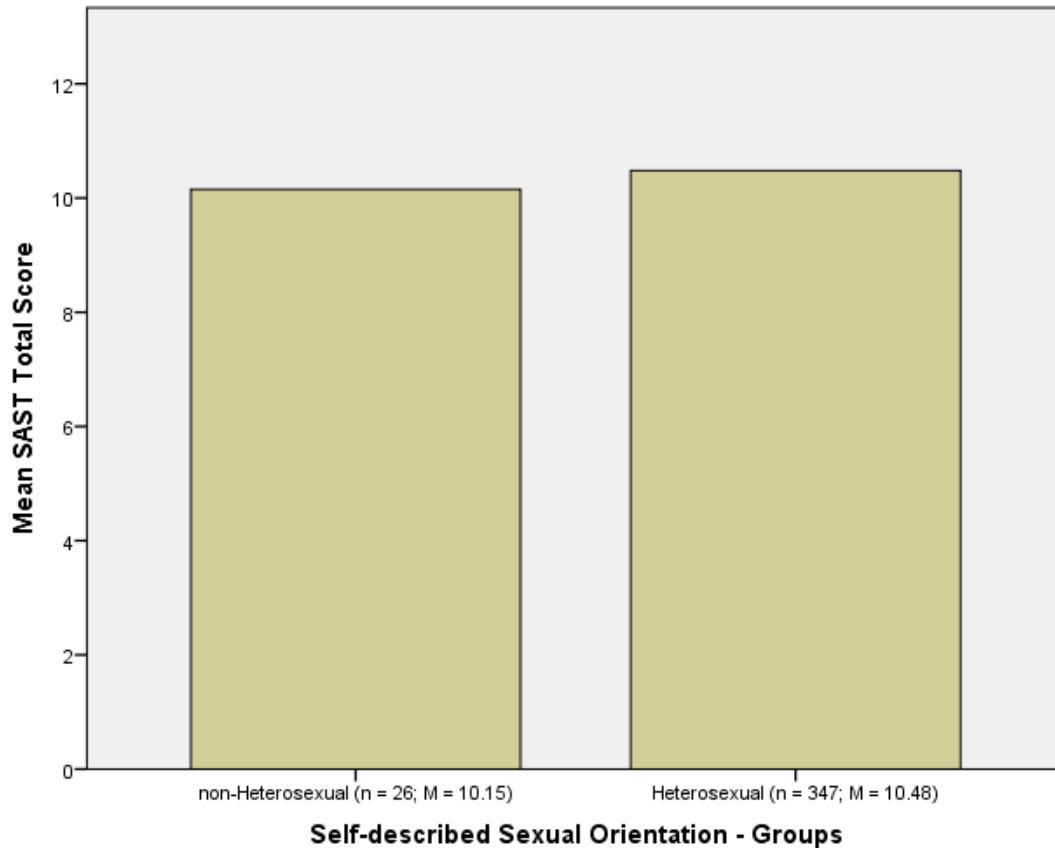


Figure 6. Self-described sexual orientation (two categories) and *SAST* mean total score

The majority of men who identified their sexual orientation as being bisexual ($n = 7$; 90%) scored above 13 on the *SAST*, which was thought to be indicative of sexual addiction (Carnes, 1989). Forty-one percent ($n = 142$) of self-described heterosexuals scored above 13 on the *SAST*. Gay men had a considerably lower percentage ($n = 1$, 6%) of scores above 13 on the *SAST*. Two categories, other (pansexual) and no indication, each had one participant, making them too small to have any significance. Participants

who reported their sexual orientation as heterosexual or gay had a mean score on the *SAST* well below the sexual addiction threshold of 13 points. These results suggested that the higher one's *SAST* score, the more commonly one would identify his sexual orientation as being bisexual.

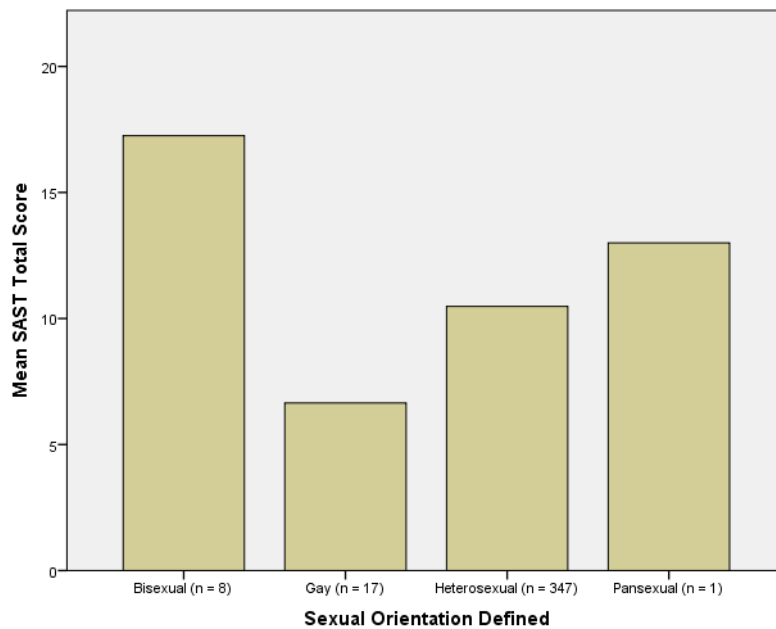


Figure 7. Self-described sexual orientation (four categories) and *SAST* mean total score

History of Sexual Abuse and Sexual Addiction

The majority of participants in this study indicated that they had not been sexually abused as children or adolescents ($n = 291$; 78.0%). Eighty-two participants (22.0%) indicated that they had been sexually abused as children or adolescents. Those participants who indicated that they were sexually abused as children or adolescents were more likely to report higher *SAST* scores compared with those who indicated they were not sexually abused as children or adolescents. Those who reported being sexually abused as children or adolescents had a mean score of 13.29 ($SD = 4.99$) on the *SAST*,

versus a mean score of 9.64 ($SD = 5.53$) on the *SAST* for those who reported not being sexually abused as children or adolescents. The correlation between history of sexual abuse and *SAST* Total Score was estimated at $r = .27, p < .001$. A two-tailed paired samples t-test revealed the null hypothesis can be rejected as the results were statistically significant, $t(372) = 35.78, p \leq .05$.

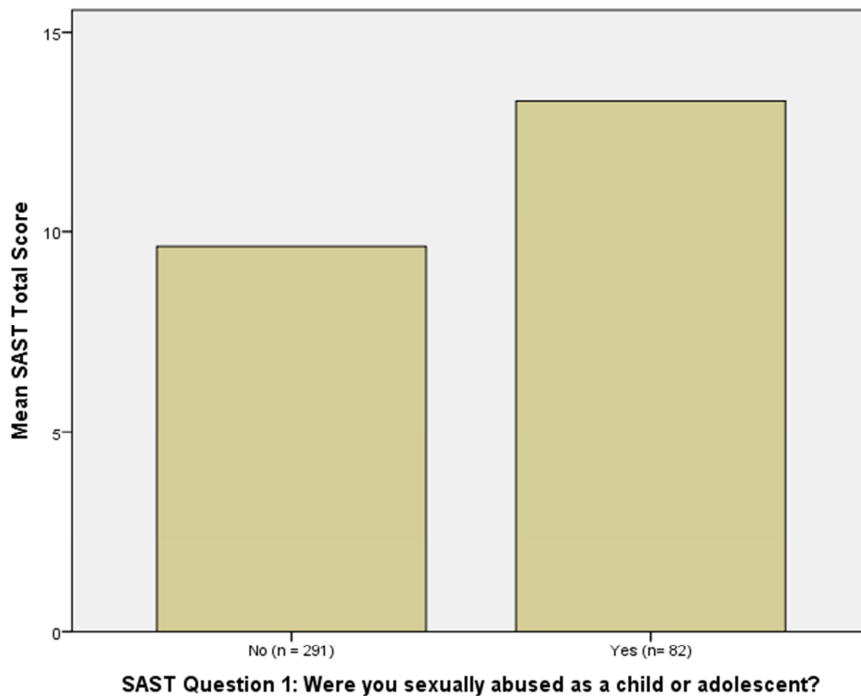


Figure 8. History of sexual abuse and *SAST* mean total score

Age and Sexual Addiction

Age was examined with regards to total score on the *SAST*. A Pearson analysis revealed there was no positive association, $r = .02$, between Age and *SAST* Total Score. The literature was limited in regards to the relationship between age and sexual addiction with the available scholarship briefly addressing the different views on the age of onset of

sexual addiction, as well as the ages where sexual addiction tended to be most problematic.

Ethnicity/Race and Sexual Addiction

The only ethnicity with strong participation in this study was White ($n = 344$, 92%). Due to the overwhelmingly large sample of white participants the data had strong limitations in regards to the other ethnicities (see Table 2). Future research would need to address this limitation and to seek to obtain stronger participation by other ethnic groups.

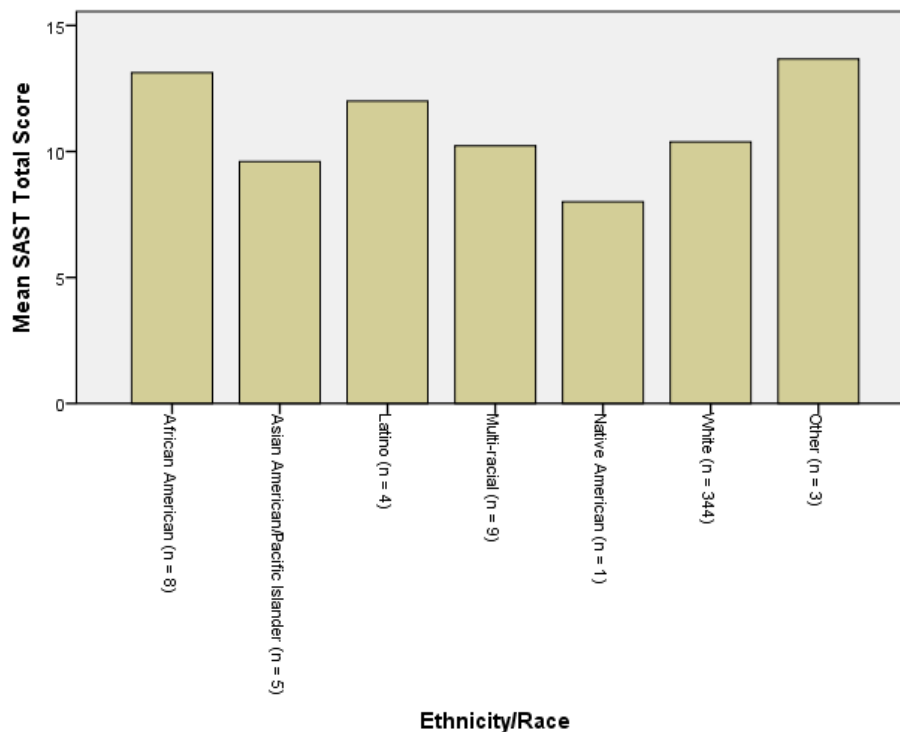


Figure 9. Ethnicity/race and *SAST* mean total score

Relational Status and Sexual Addiction

Relational Status was examined with regards to total score on the *SAST*. To assess whether there was a significant relationship between Relational Status and *SAST*

Total Score, participants were grouped into three categories, Married/Partnered/Co-habitation ($M = 10.24$, $SD = 5.75$, $N = 312$), Single ($M = 10.07$, $SD = 4.51$, $N = 43$), and Separated/Divorced ($M = 15.71$, $SD = 3.62$, $N = 18$). A one-way between-groups ANOVA was conducted. The one-way between-groups ANOVA revealed a statistically significant relationship between Relational Status and *SAST* Total Score ($F_{2,370} = 6.84$, $p = .001$). The Tukey post hoc analysis revealed significant differences between Separated/Divorced participants and both Married/Partnered/Co-habitation ($p = .001$) and Single participants ($p = .003$). There was no significant difference between Married/Partnered/Co-habitation and Single participants.

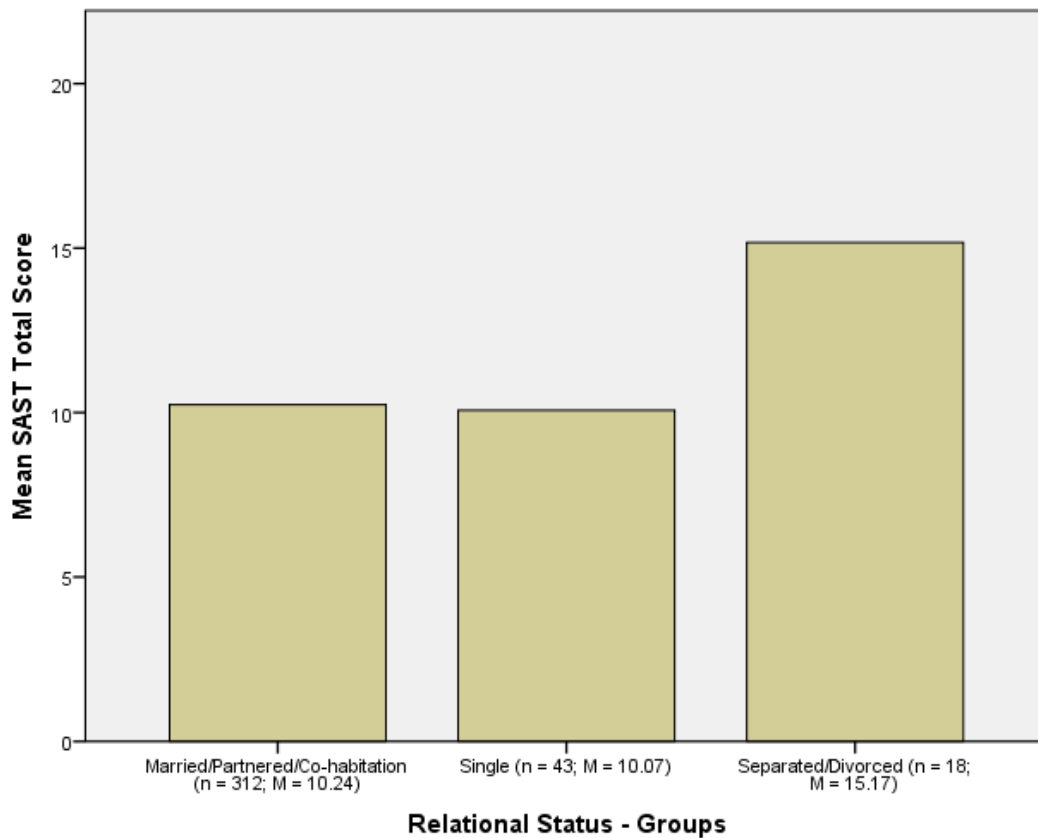


Figure 10. Relational status (three categories) and *SAST* mean total score

Married/partnered was the relational status with the strongest participation in this study ($n = 304$, 81.3%) with single being the next largest participation ($n = 43$, 11.5%) (see Table 2). Participants who indicated that they were separated or divorced reported a higher mean *SAST* score that was above the sexual addiction threshold of 13 points. The next categories of *SAST* mean scores, single, married/partnered, and widowed, fell between 10 and 12 points. Those who were cohabitating had a lower mean score on the *SAST*, scoring well below the sexual addiction threshold score of 13.

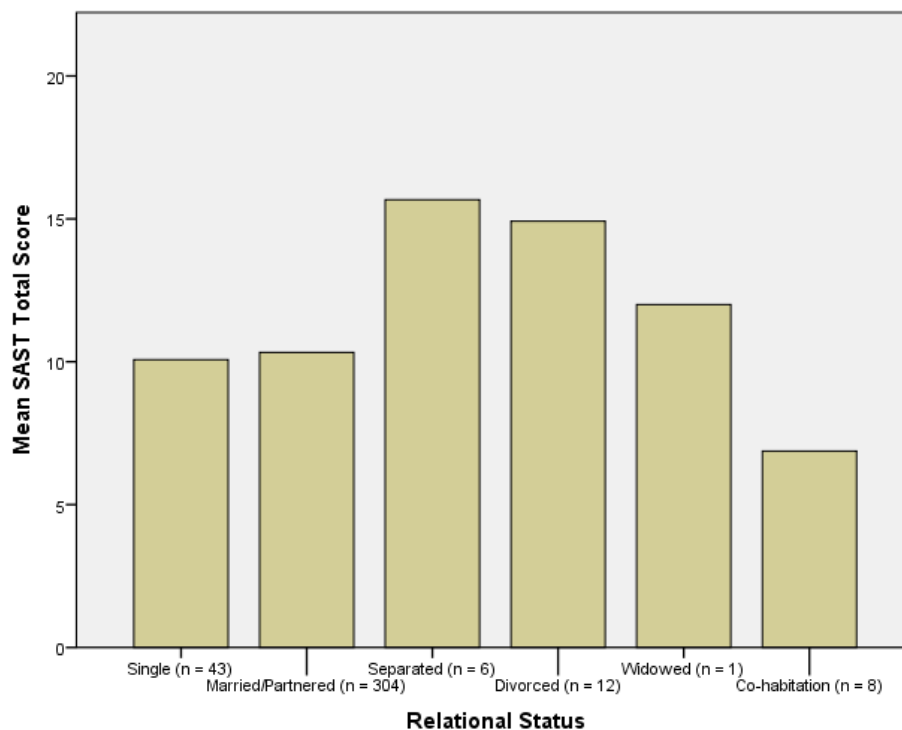


Figure 11. Relational status (six categories) and *SAST* mean total score

Socioeconomic Status and Sexual Addiction

None of the seven categories under the socioeconomic status demographic presented a mean score of 13 and above on the *SAST* (see Table 2). The mean scores ranged between 9.6 and 11.1 on the *SAST*. Socioeconomic status was examined with

regards to total score on *SAST*. A Kendall's tau analysis revealed there was no positive association, $r_{\tau} = .004$, between Socioeconomic Status and *SAST* Total Score.

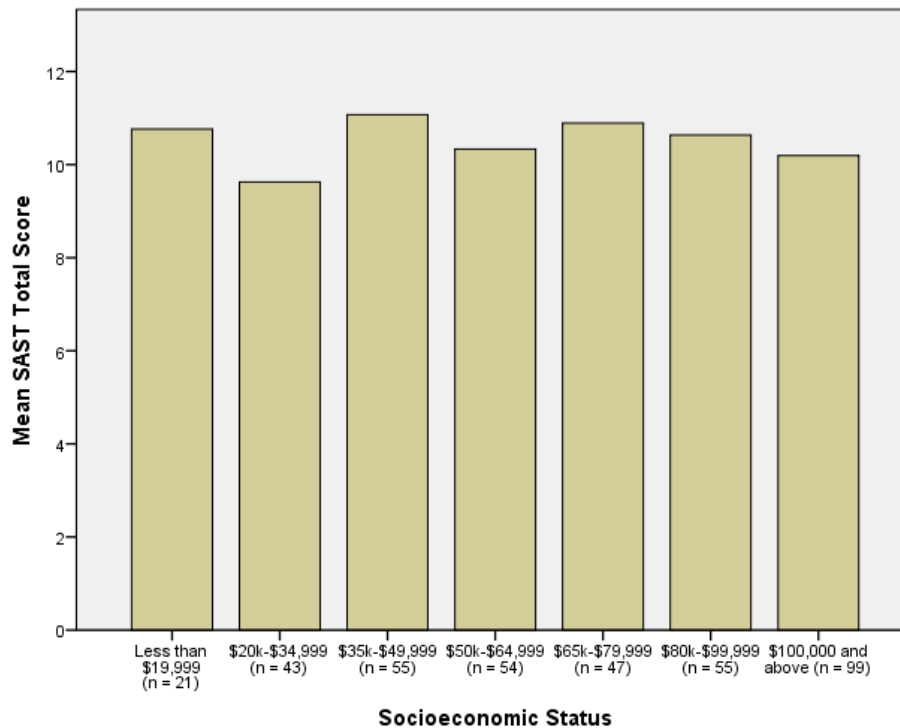


Figure 12. Socioeconomic status and *SAST* mean total score

Educational Background and Sexual Addiction

Educational background was compared to one's total score on the *SAST*. A Kendall's tau analysis revealed there was a statistically significant ($p = .001$), but negligible relationship, $r_{\tau} = -.14$, between Educational Background and *SAST* Total Score. The junior college category had the highest percentage of scores ($n = 7$, 63%) above the sexual addiction threshold of 13 on the *SAST* (see Table 2). Those with a four-year college/university degree ($n = 59$, 49%) or GED/high school degree ($n = 10$, 50%) both showed that half of their participants indicated they would potentially qualify as being sexually addicted, as they scored above 13 on the *SAST*. Approximately one-third

of those with a doctorate degree ($n = 10$, 30%) or graduate/professional degree ($n = 65$, 35%) would potentially qualify as being sexually addicted according to their scores on the *SAST* being above the sexual addiction threshold of 13 points.

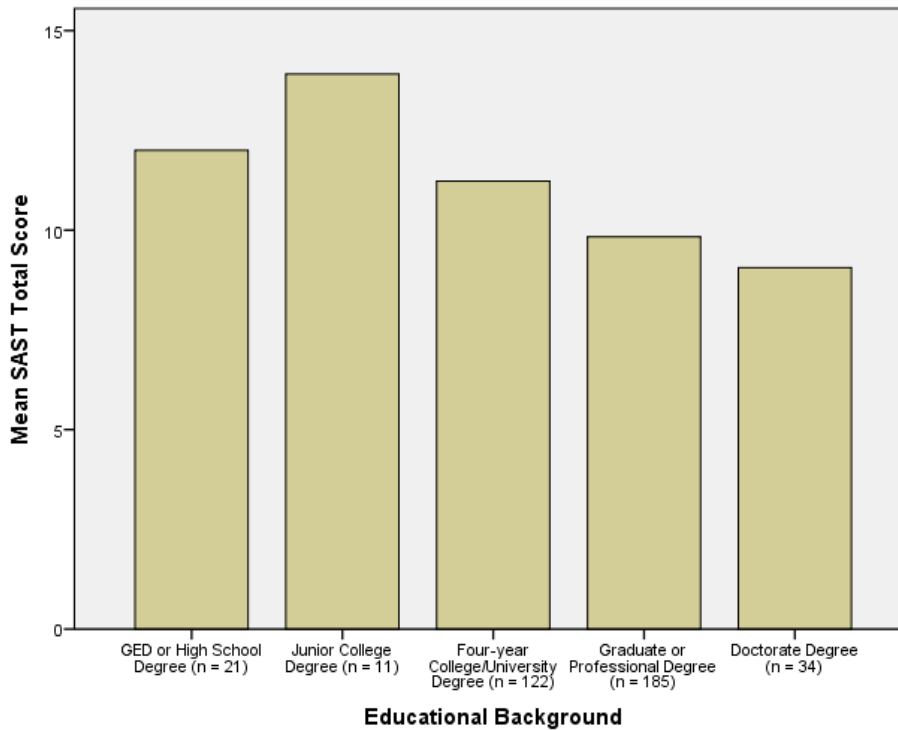


Figure 13. Educational background and *SAST* mean total score

Family Sexuality Scale

Test-Retest Reliability

The second section outlines the test-retest reliability procedure that was performed on the Family Sexuality Scale (*FSS*). Because the *FSS* was a newly developed scale specific to the present study, a test-retest reliability procedure was performed to assess the degree to which the test scores were consistent from the first test to the retest on each subscale. The two scores were correlated to assess the reliability of the test. A Pearson correlation coefficient was performed on the total score and on each of the

original four variables (communication openness regarding sexuality, derogatory/negative communication regarding sexuality, exposure to sexual stimuli, and age-inappropriate family sexual communication) of both the test and retest. See Table 1 for data results.

Thirty-two male participants from a graduate school class participated in a test-retest reliability analysis of the Family Sexuality Scale (*FSS*). The first test was administered to these participants ($M = 179.90$, $SD = 13.1$), and then two weeks later the test was administered a second time to the same participants ($M = 179.84$, $SD = 12.9$). A Pearson's r data analysis on the *FSS* total score of each test revealed a strong positive correlation, $r(30) = .78$. The *FSS* met accepted standards for temporal stability.

Regarding subscales, a Pearson correlation coefficient revealed strong significant correlations across the two administrations: Communication Openness Regarding Sexuality, $r(30) = .88$, $p < .001$; Derogatory/Negative Communication Regarding Sexuality, $r(30) = .89$, $p < .001$; Exposure to Sexual Stimuli, $r(30) = .93$, $p < .001$; and Age-Inappropriate Family Sexual Communication, $r(30) = .93$, $p < .001$.

Factor Analysis

A factor analysis was performed on the original *FSS* scale, which contained 57 items. The measure was based on the 374 male participants who completed the full survey. Using Principal Components Analysis (PCA) with oblique rotation, the number of factors were determined based on eigenvalues of 1.00 or greater and pattern factor loading of 0.4 or higher. PCA was used because the primary purpose was to identify and compute composite scores for the factors underlying the *FSS*. It was anticipated that the

factors would be intercorrelated so an oblique rotation was used in order to simplify and clarify the structure of the data. These results were described in Table 3.

After doing an oblique rotation, the first factor explained 33.25% of the variance, the second factor explained 12.80% of the variance, and the third factor explained 5.28% of the variance. A four-factor solution was explored, but did not develop, as there were an insufficient number of primary loadings in the fourth construct. The three-factor solution, which explained 51.33% of the variance, was preferred because of the “leveling off” of eigenvalues on the scree plot after three factors and the insufficient number of primary loadings in subsequent factors. The final factor-loading cutoffs for factors 1, 2, and 3 were respectively .62, .59, and .53.

After the PCA was complete and the three factors were determined, 45 items were initially available under the three factors. The *FSS* was examined for redundant items in each construct. After inter-item correlation, a high level of redundancy among items was apparent. The editing of redundant or unclear items resulted in a modified version of 22 questions for the *FSS-R*. A balance between the positive and negative direction of the items was also sought in order to maintain the response neutrality of the scale. Table 4 presented the structure correlation values for the 3-factor solution, with values < .30 suppressed. The factor labels initially proposed in the original scale were similar to the factor labels in the revised scale. Table 5 showed both the original and the revised scale. The first factor comprised of 8 items and was labeled Negative Attitudes and Communication About Sexuality; it accounted for approximately 43% of the variance. The second factor comprised of 4 items and was labeled Exposure to Sexual Stimuli; it accounted for approximately 13.1% of the variance. The third factor comprised of 10

items and was labeled Open Sexual Discussion; it accounted for approximately 5.8% of the variance.

Internal consistency for each subscale was examined using Cronbach's alpha. The alphas were adequate for, Negative Attitudes and Communication About Sexuality (.92; eight items), Exposure to Sexual Stimuli (.75; four items), and Open Sexual Discussion (.74; ten items) (see Table 6). No substantial increases in alpha for any of the subscales could have been achieved by eliminating more items. In sum, the subscales of the revised version of the *FSS* showed acceptable levels of internal consistency.

Second Test-Retest Reliability Analysis of the Family Sexuality Scale – Revised

The fourth section focused on the revision of the *FSS* after factor analysis. A second test-retest reliability procedure was performed after the results of the factor analysis were considered. These results were used to edit and reduce the final version of the *FSS-R* to 22 questions. The same data from the first test-retest reliability procedure of the *FSS* were used for the second test-retest reliability procedure. A Pearson correlation coefficient was performed on the total score and on each of the three variables that were confirmed with factor analysis (Open Sexual Discussion, Negative Attitudes and Communication about Sexuality, and Exposure to Sexual Stimuli) of both the test and retest. See Table 7 for data results.

The first test of *FSS-R* was administered ($M = 66.06$, $SD = 6.90$) and two weeks later given a second time to the same participants ($M = 65.91$, $SD = 6.39$). A Pearson's r data analysis on the total score of each test revealed a strong positive correlation, $r(30) = .85$. The test-retest reliability analysis of the *Family Sexuality Scale – Revised (FSS-R)* showed a strong positive correlation, demonstrating that the *FSS-R* was an acceptably

reliable scale. Regarding subscales, a Pearson correlation coefficient revealed strong significant correlations across the two administrations: Negative Attitudes and Communication About Sexuality, $r(30) = .85, p < .001$; Exposure to Sexual Stimuli, $r(30) = .92, p < .001$; and Open Sexual Discussion, $r(30) = .94, p < .001$.

Hypotheses

The fifth section is organized around the specific hypotheses related to the relationship between family factors (as measured by the *FSS-R*) and sexual addiction. The first and third hypotheses (negative attitudes and communication about sexuality, open sexual discussion) were modified due to the factor analysis. The changes are found in this section. Correlational analysis was used to analyze whether there was a relationship between a man's sexually addictive behavior and the manner in which his family-of-origin handled sexuality. This analysis was performed with the *FSS-R* subscales (*FSS-R* Negative Attitudes and Communication About Sexuality, *FSS-R* Exposure to Sexual Stimuli, *FSS-R* Open Sexual Discussion score) and *SAST* scores.

Hypothesis 1

Hypothesis 1 (H_1) predicted that higher levels of negative attitudes and communication about sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction. To assess whether there was a significant relationship between negative attitudes and communication about sexuality in one's family-of-origin and sexual addiction, a correlational analysis was conducted. A Pearson's r data analysis revealed a positive correlation, $r = .39$, between *FSS-R* Negative Attitudes and Communication About Sexuality and *SAST* score. Participants who scored higher on the *FSS-R* Negative Attitudes and Communication About Sexuality section showed a

moderate, but highly significant positive correlation with a higher score on the *SAST* at $p < .01$. The relationship was modest and showed that the greater the negative attitude and communication about sexuality in one's family-of-origin the higher the *SAST* score.

Hypothesis 2

Hypothesis 2 (H_2) predicted that higher levels of exposure to sexual stimuli in one's family-of-origin would correlate positively to a measure of sexual addiction. To assess whether there was a significant relationship between exposure to sexual stimuli in one's family-of-origin and sexual addiction, a correlational analysis was conducted. A Pearson's r data analysis revealed a weak correlation, $r = .15$ between *FSS-R* Exposure to Sexual Stimuli and *SAST* score. Participants reporting more exposure to sexual stimuli had higher *SAST* scores at $p < .01$. The relationship showed that the greater the exposure to sexual stimuli in one's family-of-origin the higher the *SAST* score.

Hypothesis 3

Hypothesis 3 (H_3) predicted that less open sexual discussion in one's family-of-origin would correlate positively to a measure of sexual addiction. To assess whether there was a significant relationship between open sexual discussion in one's family-of-origin and sexual addiction, a correlational analysis was conducted. A Pearson's r data analysis revealed an inverse correlation, $r = -.35$, between *FSS-R* Open Sexual Discussion and *SAST* score. Participants who scored higher on the *FSS-R* Open Sexual Discussion section showed a moderate, but highly significant inverse correlation with a higher score on the *SAST* at $p < .01$. A moderate, inverse correlation showed that the more open the sexual discussion in one's family-of-origin, the lower the *SAST* total score was.

Summary

This study surveyed men to assess whether any correlations existed between a man's sexually addictive behavior and how his family-of-origin addressed sexuality. The purpose of this study was to determine whether there were any consistent family-of-origin characteristics in men who engaged regularly in sexually addictive behavior, as well as to discover whether there were any associations with sexual addiction and specific demographic factors. The Family Sexuality Scale (*FSS*) was a newly developed scale specific to the present study. A test-retest reliability procedure was performed on the *FSS* to assess the degree to which the test scores were consistent from the first test to the retest on each subscale. An exploratory factor analysis procedure was then performed on the original *FSS* scale. This helped to explain the connections that were made between certain factors and the observed variables. A second test-retest reliability procedure was performed on the *FSS-R* after the results of the factor analysis were considered and used to edit the final version of the *FSS-R*. The final version of the *FSS-R* consisted of 22 questions. The instrument met acceptable standards of reliability.

All three hypotheses were supported. Hypothesis 1 (H_1) predicted that higher levels of negative attitudes and communication about sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction. Hypothesis 2 (H_2) higher levels of exposure to sexual stimuli in one's family-of-origin would correlate positively to a measure of sexual addiction. Hypothesis 3 (H_3) predicted that less open sexual discussion in one's family-of-origin would correlate positively to a measure of sexual addiction. A discussion of the study's findings will be presented in the next chapter.

CHAPTER V

DISCUSSION

This chapter presents a summary of the study and important conclusions drawn from the data presented in chapter four. It also provides a discussion of the implications for action and recommendations for further research. The purpose of this study was to determine whether there were any consistent demographic or family-of-origin characteristics in men who engaged regularly with sexually addictive behavior. The researcher examined the data for any correlations that might exist between a man's sexually addictive behavior and how his family-of-origin addressed sexuality. Research that addressed this issue was available, but most of it was either out of date, anecdotal, or did not provide empirical validation (Carnes, 1992; Laaser, 2002; Matheny, 2002; Phillips, 2006). This study was intended to address the anecdotal evidence with research data and to encourage future research.

Research Questions and Hypotheses

Initially the main research question for this study was as follows: Is there a relationship between demographic variables (including (a) age, (b) ethnicity/race, (c) relational status, (d) educational background, (e) socioeconomic status, (f) sexual orientation, and (g) history of sexual abuse) or family factors (including (a) communication openness, (b) derogatory and negative communication, (c) exposure to sexual stimuli, and (d) age-inappropriate sexual communication) and sexual addiction? After the factor analysis, the variables under family factors changed to (a) negative attitudes and communication about sexuality in one's family-of-origin, (b) exposure to sexual stimuli in one's family-of-origin, and (c) open sexual discussion in one's family-

of-origin. The results of the factor analysis will be discussed later. The first hypothesis stated that higher levels of negative attitudes and communication about sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction. The second hypothesis stated that higher levels of exposure to sexual stimuli in one's family-of-origin would correlate positively to a measure of sexual addiction. The third hypothesis stated that less open sexual discussion in one's family-of-origin would correlate positively to a measure of sexual addiction.

Summary of the Study

As previously stated, the pioneering work and influence of Patrick Carnes on the topic of sexual addiction (Adams & Robinson, 2001; Giugliano, 2009; Laaser, 1996b, 2003) underlay this dissertation. Sexual addiction, according to Carnes (1983, 1989, 1991, 2001b), is an intimacy disorder that manifests in a compulsive cyclical pattern. According to Carnes (1983, 1989, 1991, 2001b), those who are sexually addicted have an inability to adequately attach and bond in intimate relationships. Carnes (1983) believed that this difficulty was tied to issues surrounding one's family-of-origin, and he viewed sexual addiction as a way one sought to compensate for early family-of-origin problems and attachment failures, as well as for present day problems (Carnes, 1983).

Many experts believed that there had been a major increase of sexual addiction in the United States during recent years (Albright, 2008; Carnes, 2011; Carnes et al., 2007; Cooper et al., 2000a; Cooper et al., 2000b; Cooper et al., 2002; Daneback et al., 2006; Ropelato, 2011). Because of this increase, there needed to be a greater understanding about the correlates and causes of sexual addiction in order to prevent it from occurring and to better help those who already struggled with it. Understanding the roots of an

addiction was a major part of the process of helping those caught in it. The addict's family-of-origin was believed to play a crucial role in the development and continuation of an addiction. As stated before, there was a limited body of research that specifically addressed the relationship between one's family-of-origin and sexual addiction. Much of the evidence was anecdotal, and needed to be empirically confirmed, supported, or disputed. This research was intended to fill research gaps and to encourage future research in this area of study. The intent of this study was to improve the understanding of the ways that male sexually addictive behavior was related to certain demographic factors and examine the data for any correlations that might have existed between a man's sexually addictive behavior and how his family-of-origin addressed sexuality.

Focusing on how one's family-of-origin handled sexuality could be beneficial in many different ways. It could help therapists working with sexually addicted men, or those men struggling with sexually addictive behavior, to better understand their family-of-origin and to begin to connect their addiction to their story. This could also benefit parents rearing their children in a highly sexualized Internet culture. This information could also benefit parents by helping them understand the impact of how they handle sexuality in the home. Understanding some of the dynamics involved in the formation of sexual addiction could help parents to choose healthy parenting patterns, thus helping them to protect their children from future sexual addiction. This information could also help mental health professionals and developmental psychologists to formulate possible methods of prevention of sexual addiction later in adulthood.

Discussion of Findings

Hypothesis 1

The first hypothesis of this study, that higher levels of negative attitudes and communication about sexuality in one's family-of-origin would correlate positively to a measure of sexual addiction, was supported, and the null hypothesis was rejected. A Pearson's r data analysis revealed an adequate, positive correlation, $r = .39$, between *FSS-R* Negative Attitudes and Communication About Sexuality and *SAST* score. An adequate, positive correlation showed that there was a relationship between negative attitudes and communication about sexuality in one's family-of-origin and one's *SAST* score. This seemed to indicate that a male whose family-of-origin expressed negative attitudes and communication about sexuality in the home had a greater probability of becoming sexually addicted.

The topic of negative attitudes and communication about sexuality in the family environment was not directly mentioned in the literature. Because of this, the present study broke new ground by introducing the influence of one's family-of-origin as an important topic in the area of sexual addiction. More research is needed in order to expand the available knowledge on the significant relationship between negative attitudes and communication about sexuality in one's family-of-origin and sexual addiction.

Sexual communication was mentioned in the literature in general ways, but on the specific topic of negative and derogatory communication in the family environment, the literature was extremely limited. Nothing was directly mentioned regarding this topic. The literature addressed the opposite notion, i.e. healthy sexual communication in family environments. Two articles indicated that a family with regular negative sexual

communication among family members was believed to show an increase of early sexual behavior in children (Bersamin et al., 2008; Pawlowski, 2006). Though this might lead to sexual addiction, the link has not been clearly established. In light of this, the present study introduced an important topic to the area of sexual addiction that was not directly found in the literature. More research is needed in order to expand available knowledge on the significant correlation between sexual addiction and negative attitudes and communication regarding sexuality in one's family-of-origin.

Hypothesis 2

The second hypothesis predicted that higher levels of exposure to sexual stimuli in one's family-of-origin would correlate positively to a measure of sexual addiction. This hypothesis was supported in this study, and the null hypothesis was rejected. A Pearson's r data analysis revealed a weak correlation, $r = .15$, between *FSS-R* Exposure to Sexual Stimuli and *SAST* score. A weak correlation showed that even though there was a significant relationship with the *FSS-R* Exposure to Sexual Stimuli section and the *SAST* score, there was not a strong relationship between exposure to sexual stimuli in one's family-of-origin and one's *SAST* score. This indicated that growing up in a family where exposure to sexual stimuli was commonplace might relate to sexual addiction in adulthood.

The literature was limited on the impact of pornography exposure among children and teenagers (Braun-Courville & Rojas, 2009). Anecdotally, many therapists reported that a high percentage of their clients who were sexually addicted were introduced to pornography at an early age (Boies et al., 2004). This was countered by another article in the literature (Štulhofer et al., 2008), which indicated there was no connection between

sexual addiction in adult men and early exposure to pornography. More research was needed to explore the relationship between demographic variables and exposure to sexual stimuli.

The present study agreed with the assessment that has been reported anecdotally from therapists that sexually addicted clients tend to have been exposed to pornography and other sexual stimuli at an early age. The present research showed a weak, yet significant correlation. This disagreed with the findings of Štulhofer et al. (2008), who found no connection between sexual addiction in adult men and early exposure to pornography. The observations of Štulhofer et al. (2008) also made sense in light of the weak correlation found in the present study.

According to Mitchell et al. (2003), no research had been conducted on whether exposure to pornography and other sexual materials caused psychological, moral, or developmental harm to children. The literature did not provide much information on the impact of pornography exposure among children and teenagers (Braun-Courville & Rojas, 2009). A major piece of the literature surrounding the relationship between exposure to pornography during childhood and sexual addiction in adulthood was related to the topic of children who were exposed to unwanted pornography without searching for it (Duimel & de Haan, 2006; Flood, 2007, 2009; Sabina et al., 2008; Soeters & van Schaik, 2006). No research specifically addressed the impact of unwanted or unexpected exposure to pornography among children and adults (Mitchell et al., 2003).

Young people who used pornography were believed to be more likely to have experienced early sexual involvement, sexual intercourse, masturbation, same-gender sex, one-night stands, and anal intercourse (Flood, 2009; Haggstrom-Nordin et al., 2005;

Johansson & Hammarén, 2007; Rogala & Tyden, 2003; Tyden et al., 2001; Tyden & Rogala, 2004) than those who did not use pornography (Huston et al., 1998; Strasburger & Wilson, 2002; Ward, 2003; Wingwood et al., 2001). These articles did not specifically refer to sexual addiction, but rather to behaviors that might lead to or overlap with sexual addiction.

This study introduced an important topic to the area of sexual addiction that was addressed only sparsely in the literature. More research is needed in order to expand available knowledge on the significant relationship between exposure to sexual stimuli in one's family-of-origin and sexual addiction.

Hypothesis 3

The third hypothesis stated that less open sexual discussion in one's family-of-origin would correlate positively to a measure of sexual addiction. The hypothesis was supported in this study, and the null hypothesis was rejected. A Pearson's r data analysis revealed an adequate, negative correlation, $r = -.35$, between *FSS-R* Open Sexual Discussion and *SAST* score. An adequate, negative correlation showed that there was a relationship between openness of sexual discussion in one's family-of-origin and one's *SAST* score. It showed that the more open the sexual discussion in one's family-of-origin, the lower the *SAST* total score would be. A consistent relationship between the two variables was shown. This indicated that a man who grew up in a family that practiced open sexual discussion was less likely to show sexually addictive behavior in adulthood.

The literature regarding parental engagement and communication with children about sexuality was shown to be limited (Rosenthal & Feldman, 1999). The literature

showed that parents played an influential role in determining the course of their children's views on sexuality and sexual behavior (Fisher, 2001; Greenfield, 2004). This influence tended not to appear until late adolescence (Fisher, 2001). The literature indicated that parents who were proactive about discussing topics of sexuality with their children helped to protect them from potential future negative sexual consequences, such as sexual addiction (Bersamin et al., 2008; Karofsky et al., 2000). A warm and communicative relationship between parent and child was seen to reduce sexual risk-taking and to be the best way to deal with the challenges of a pornographic and sexualized media environment (Greenfield, 2004). A number of studies reported that frequent parental communications about sexuality was often associated with healthy and responsible sexual outcomes (Jaccard & Dittus, 1991; Leland & Barth, 1993; Pick & Palos, 1995; Ward & Wyatt, 1994). In contrast to this, Miller (1998) (see also Rosenthal & Feldman, 1999) observed no connection between the amount or style of how parents communicated with their children about sex and later adolescent sexual behavior.

One article (Corley, 2005) discussed the concept of sexually healthy families. According to Corley (2005), sexually healthy families were places where parents considered sexual communication and education to be important. Sexually healthy families had parents that were approachable, proactive, and sought to use teachable moments with their children (Corley, 2005). The members of these families knew that their behavior and actions spoke louder than their words, and they believed that their behavior should be consistent with their values (Corley, 2005). Sexually healthy families understood and allowed for privacy and a respect for boundaries (Corley, 2005). They

also allowed children to ask parents questions, they prepared adolescents for puberty, and they allowed adolescents to make age-appropriate decisions (Corley, 2005).

The literature alluded to two sides of the spectrum of family types that led to sexual addiction. One was where the family was extremely rigid or silent about sexuality (Adams & Robinson, 2001; Carnes, 1988; Schneider, 1989; Sprenkle, 1987). In this type of family culture, sex was not discussed in healthy, appropriate ways. Rather, sex was connected to shame and fear, and family members were forbidden to discuss the topic except in ways that were ultimately unhealthy and inappropriate. The other type of family was extremely open, with no boundaries on issues of sexuality (Carnes, 2000; Schneider, 1989; Widmer, 1997).

Though it was widely believed that parents should be the primary source of sexual education for children, the literature indicated that parents were not the primary source of such education (Abrams et al., 1990; Ansuini et al., 1996; Rosenthal & Feldman, 1999; Rosenthal & Smith, 1995). The literature showed that it was common for parents to avoid discussing important issues about sexuality with their children (Pawlowski, 2006). Because of this, it was believed that children tended to learn about sexuality from potentially harmful and unreliable sources, such as their friends, siblings, the Internet, and other media sources (Pawlowski, 2006). Greenfield (2004) believed that those whose parents provided little sexual education tended to be more vulnerable to the influences of pornography and sexually explicit media than those who received an adequate level of sexual education through childhood and the adolescent years. Pawlowski (2006) indicated that a lack of proper guidance from their parents might have set children up for sexual difficulties and behaviors that may have potentially caused great harm. Though

not specifically addressing sexual addiction, there was a strong connection to sexually addictive behavior.

A highly restrictive and conservative attitude, where sex was not discussed in healthy, appropriate ways was seen to be a common family dynamic in the lives of many sexual addicts (Sprenkle, 1987). In these families, sex was easily connected to shame and fear, so family members were forbidden to discuss the topic. In this type of family, a child's feelings and thoughts regarding sexuality were not normalized, but rather viewed as inappropriate topics for discussion. This could have caused a child to feel shame about their sexuality, encouraging the future addict to become highly secretive about his sexual behavior and to suppress any sexual impulses. Ultimately, this suppression could have made those impulses more compelling (Sprenkle, 1987). The cycle of addiction began and continued to grow as the future addict tried to hide from the shame. The addiction cycle and shame became self-perpetuating as the addict continued to cope with their emotions.

The literature also showed that disengaged families-of-origin with rigid rules and insufficient nurturing were common among sexual addicts (Carnes, 1988; Schneider, 1989). According to Carnes' (1988), who studied sexual addicts and their families over a seven-year period, 68% ($n = 1,000$) of sexual addicts fell into the rigid, disengaged family category (see also Schneider, 1989). Carnes (2000) found that more than 87% ($n = 251$) of the patients treated for sexual addiction were reared in family environments that were disengaged, where family members were uninvolved, detached, or emotionally absent. Carnes (2000) believed this was a clear sign of an intimacy disorder that was often associated with sexually addictive behavior.

The present study supported the conclusion that less open sexual discussion in one's family-of-origin would correlate positively to a measure of sexual addiction. This conclusion was also in agreement with the literature. More research is needed in order to expand available knowledge on the significant relationship between open sexual discussion in one's family-of-origin and sexual addiction.

Demographics and Sexual Addiction

Sexual Activity

Sexual orientation with respect to sexual activity/behavior was compared to one's total score on the *SAST*. A statistically significant relationship was found between sexual activity and *SAST*. The results from this study indicated that the higher one's *SAST* score, the more commonly one would report one's sexual activity as being primarily in the middle section of the spectrum where sexual activity was more often with both sexes (cf. bisexuality). This study seemed to indicate that the lower one's *SAST* score, the more commonly one would emerge on the end of the spectrum where sexual activity was "primarily with one sex" or in the category where one has never had sex. These results seemed to contrast with the literature, where a number of articles pointed to a strong link between sexual addiction and high-risk sexual behavior among MSM (men who have sex with men) (Benotsch et al., 1999; Dodge et al., 2004; Grov et al., 2008; Grov, Parsons, & Bimbi, 2010; Kalichman et al., 1994; Kalichman & Rompa, 1995, 2001; Kalichman et al., 1997; O'Leary et al., 2005; Parsons et al., 2001; Reece, Plate, & Daughtry, 2001). More research is needed to explore the dynamic between sexual activity and sexual addiction, especially bisexual activity that appeared to score highest on the *SAST*.

Sexual Attraction

Sexual orientation with respect to sexual attraction was compared to one's total score on the *SAST*. A statistically significant relationship was found between sexual attraction and *SAST*. The results from this study seemed to indicate that the higher one's *SAST* score, the more commonly one would report being in the middle of the spectrum, where attraction was towards both sexes (cf. bisexuality). These two categories (more attracted to the same sex and more attracted to the opposite sex) had mean scores above 13 points on the *SAST*, indicating the potential presence of sexual addiction (Carnes, 1989). The other categories fell below the 13-point threshold of sexual addiction, with those who were mostly attracted to the same sex scoring significantly lower than the other categories. Nothing in the literature was specific to sexual orientation, with respect to sexual attraction defined, and sexual addiction. More research is needed to explore the dynamic between sexual attraction and sexual addiction, especially attraction towards both sexes that appeared to score highest on the *SAST*.

Self-described Sexual Orientation

Sexual orientation with respect to self-described sexual orientation was compared to one's total score on the *SAST*. A statistically significant relationship was found between self-described sexual orientation and *SAST*. The results from this study seemed to indicate those who reported their sexual orientation as bisexual scored significantly higher on the *SAST* ($M = 17.3$; $SD = 3.7$; $N = 8$) than gay and heterosexual men, being well above the sexual addiction score of 13 points. Gay men had the lowest average score on the *SAST* ($M = 6.7$; $SD = 3.4$; $N = 17$), with heterosexual men scoring between the two ($M = 10.48$; $SD = 5.6$; $N = 347$).

The present study gave some clarity to the limited literature regarding sexual addiction and self-described sexual orientation. Cooper et al. (2000) believed that cybersex addiction was more common among gay and bisexual males than among heterosexual men (cf. Grov, et al., 2008; Grov, et al., 2010). Dahlen et al. (2008) disagreed with Cooper et al. (2000), as they believed the majority of American men who struggle with sexual addiction were heterosexual. These discrepancies raised questions about which perspective was more accurate, and why they differed. More research is needed in this area to better understand whether there is a correlation between self-described sexual orientation and sexual addiction, especially bisexual activity that appeared to score highest on the *SAST*.

When comparing the answers to the three different questions about sexual orientation, the results did not appear to correspond to one another. For the question, “How would you define your sexual activity or behavior?”, those participants who indicated they had all sex with the opposite sex ($n = 286$) made up 76.5% of the respondents while those who indicated they had all sex with the same sex ($n = 38$) made up 10.2% of the respondents. In response to the question, “How would you define your sexual attraction?”, those participants who indicated that they were totally attracted to the opposite sex ($n = 290$) made up 77.5% of the respondents, while those who indicated that they were totally attracted to the same sex ($n = 35$) made up 9.4% of the respondents. In comparison, the research showed that those who identified themselves as gay ($n = 17$; 4.5%) were much smaller in number than those who identified themselves as having a sexual activity preference of all sex with the same sex ($n = 38$; 10.2%) and a sexual orientation of totally attracted to the same sex ($n = 35$; 9.4%).

The literature gave some insight into these discrepancies. The literature indicated that a common occurrence in sexual addiction treatment amongst male clients who often had sex with men was that they saw themselves as “not gay-identified” (Perry & Barry, 1998). This meant that they did not identify themselves as gay, even though they had sex with men. It was common for these men to live secret lives, since their primary relationships were heterosexual. Often, they strongly refused to be identified with the gay community (Perry & Barry, 1998). This fit the present research, where a high number of self-identified heterosexual men indicated that they primarily had sex with the same sex. Similar to Perry and Barry (1998), it appeared that a number of men were hesitant to identify themselves as gay or bisexual, even though they were sexually engaged with other men. According to Perry and Barry (1998), in some cases male clients had primary partners or relationships that were heterosexual, and they were living secret lives. There was often a determination not to be identified with the gay community (Perry & Barry, 1998).

History of Sexual Abuse

History of sexual abuse was compared to one’s total score on the *SAST*. The results from this study were statistically significant and seemed to indicate that the higher one’s *SAST* score, the more commonly one would report having a history of sexual abuse. The connection between sexual addiction and a history of childhood sexual abuse was quite strong and presented clearly in the literature (Aaron, 2012; Adams & Robinson, 2001; Anderson & Coleman, 1991; Carnes, 1989, 1991, 2000, 2001b; Carnes & Delmonico, 2006; Coleman, 1991; Gold & Heffner, 1998; Kort, 2004; Kuzma & Black, 2008; Laaser, 2003, 2006; Parsons, Grov, & Golub, 2012; Perera, Reece, Monahan,

Billingham, & Finn, 2009; Reid & Woolley, 2006; Rickards & Laaser, 1999; Schneider, 1989; Schneider, 2000; Schwartz, Galperin, & Masters, 1995; Schwartz & Masters, 1994; Schwartz & Southern, 2000; Spiegel, 2008; Sprenkle, 1987; Tedesco & Bola, 1997).

Ethnicity/Race

Ethnicity/race was compared to one's total score on the *SAST*. The results from this study could not be examined due to the overwhelmingly majority of white participants ($n = 344$, 92%). A review of the literature showed that most of the research on sexual addiction was unrelated to any specific culture. Previous research on the effects of sexual addiction among minority groups was also limited. According to Giugliano (2008), there was "no research on sexual addiction among people of color" (p. 149). A majority of the literature was generic in relation to the population studied, with only a few articles hinting that they had a Caucasian population base. Very few of the articles reviewed acknowledged that their studies were limited by the lack of racial and ethnic diversity among the population studied. Robinson (1999) was the only article that addressed sexual addiction from a multicultural perspective rather than from a Caucasian perspective. Robinson (1999) linked sexual addiction with PTSD in the African American community, as a source of coping with past and present trauma.

Relational Status

Relational status was compared to one's total score on the *SAST* and demonstrated that there was not a statistically significant relationship. The results from this study seemed to indicate that those participants who were separated and divorced were more likely to report a higher mean *SAST* score. The literature was quite limited with respect to the relational status of sexual addicts. Two studies, Daneback, Ross, and Mansson

(2006) and Cooper, McLoughlin, and Campbell (2000b), both showed that sexual addicts were more likely to be in a relationship. Cooper, Delmonico, and Burg (2000a) found that 80% of the sexually addicted respondents in their study were either married, in a committed relationship, or dating. The results of the present study were not in agreement with the literature.

Cooper et al. (2000b), in looking at cybersex addiction, showed that those who were married were “less vulnerable to cybersex compulsion” (p. 22), while those who were single and dating were more likely to fit the category of cybersex addiction (p.12). Dew et al. (2006), in alluding to sexually addictive behavior, pointed to the appealing nature of the anonymity and accessibility of the Internet, which allowed homosexual and bisexual men who were in heterosexual marriages to meet potential male sex partners. The Internet provided a “safe” place for these men to meet other men and to seek out sexual partners without being “outed” (Dew et al., 2006, p. 203). This seemed to indicate that one’s sexual behavior, whether online or offline, had some association to one’s relational status. No explanations, only hypotheses, were given for these results. More research was needed on sexual addiction in light of relational status.

Socioeconomic Status

Socioeconomic status was compared to one’s total score on the *SAST* and demonstrated that there was not a statistically significant relationship. There was a very limited amount of literature on the socioeconomic status of sexual addicts, and no studies showed a correlation between sexual addiction and socioeconomic status. The three articles in the literature related to this topic had similar findings to one another, where

sexual addiction was found to have a greater presence in both the middle and a lower socioeconomic status (Carnes, 1989; Marshall et al., 2008; Marshall & Marshall, 2010).

Educational Background

Educational background was compared to one's total score on the *SAST* and demonstrated that there was a statistically significant, but negligible relationship. It was unclear why those who had completed a junior college degree received the highest score, which was above the sexual addiction threshold on the *SAST*. More research is needed to understand the dynamics underlying the relationship between sexual addiction and educational background. No literature was available on the educational background of sexual addicts.

Limitations

With correlational studies, one could not imply or prove causation. A cause and effect relationship could not be established even if the data were highly significant. Correlational research only allowed one to predict a variable from another variable, thus showing that they were associated. Variables could have been associated and still not have had a causal relationship between them. Causal conclusions could not have been made from correlational findings. There was always the possibility of another explanation for the findings. One could only have ascertained that any statistically significant results were merely correlations and did not imply causality.

The sample for this study was a convenience sample, with the resulting limitation of sampling bias. This led to potential biases due to selecting-in those participants who had an interest in this topic, and therefore might not have been representative of the larger population. Because the sample was not representative of the entire population, it was

possible that the results from a convenience sample differed significantly from the results of studying the entire population. Findings could not have been generalized to the population because the groups would have been derived demographically from a convenience sample.

Additional limitations would have included the possibility that individuals could have been excluded from participation in this study due to their inability to access the Internet. The survey was solely accessed through the Internet, so there was potential that this could have over-represented younger participants, as they tended to be more Internet savvy and spend more time online than their elders (Schonlau, Fricker, & Elliott, 2002). The Internet could have isolated certain participants, attracting only those who used the Internet.

Another limitation of this study was the use of an online survey. It was possible for participants to not meet inclusion requirements, such as being eighteen years or older and male, and still participate in the survey. There was always the chance that a participant could have lied about who they were, their identity, age, and the answers to the scale. Although it would have been impossible to completely prevent this, certain attempts were made. For example, the online survey included components that asked participants to answer questions related to their age and gender in hopes of identifying those participants who were under the age of 18 or who were female. Participants were asked to enter their current age and their date of birth in separate questions in order to highlight discrepancies. If they did not meet the inclusion criteria, the online survey was setup to direct participants out of the survey, thank them for their time, and ask them to

forward information about the survey to others who would meet the inclusion criteria. These were all reviewed in order to assess whether participants met inclusion criteria.

Other factors of measurement that might have skewed the results of the proposed research were related to the participants' memories and views of their families-of-origin. Participants might have mistaken memories and not remembered everything clearly. They might have tried to please the researcher and not answered the scales honestly. They might have lied to make themselves look better in the researcher's eyes. Interpersonal relationships are quite complex and difficult to measure. Some participants might have seen their family-of-origin as perfect or normal when it might not have been as normal when compared to an objectively healthy family. Some participants might have been afraid to criticize their family, and thus not report how things really were in their family-of-origin.

Another limitation of this study was related to the number of participants who accessed the survey, but were not included in the final overall sample of 374 participants. This mainly included those who did not fully complete or even begin the survey. There were 521 potential participants who started the survey, but 147 participants did not complete the survey. Some of the participants might have been initially motivated to participate in the research, but were less likely to complete the survey due to its length. Potential participants were not given an indication of how long the survey would take to complete.

A seventh limitation was the focus on males, rather than including both males and females. The findings of this research might only be applied to males and could not be generalized to females.

An eighth limitation was related to the *SAST* and the indicated sexual addiction cutoff score of 13 or higher (Carnes, 1989; Carnes et al., 2010). This might be too liberal in criterion for a definition of sexual addiction. More research is needed to clarify whether or not 13 is an accurate cutoff score or if there is a more precise score that indicates sexual addiction.

A ninth limitation to this study was the low number of participants who self-identified as other than heterosexual, which limited generalization of these results to heterosexual men.

Finally, the data used in the hypothesis testing were collected on the initial Family Sexuality Scale (*FSS*) which was a much larger instrument from the later revised version (*FSS-R*). This could have affected results.

Implications for Action

This study, regarding the impact of how families-of-origin handled sexuality, will benefit the sexual addiction community, including therapists, family members, and addicts. It could help therapists and men struggling with sexually addictive behavior to better understand their family-of-origin and connect their story to their addiction. Exploring this connection to the present day could help sexual addicts be more aware of triggers and issues that keep them trapped in their addiction. This could also be beneficial to spouses, as they walk with their partner through their addiction recovery, to better understand some of the reasons for the addiction and the continuous struggle with certain behaviors.

The present study might also benefit parents as they guide and care for their children in an Internet culture that is highly sexualized (Bale, 2011; Mitchell et al., 2003;

Mitchell et al., 2007; National Center on Addiction and Substance Abuse, 2004; Ropelato, 2011; Wolak et al., 2007). Understanding the dynamics of sexual addiction could help parents think through healthy paths of parenting, thus helping them to prevent and protect their children from future sexual addiction. This study might help parents be more aware of how they handle the issue of sexuality as they parent, in order to protect and prevent their children from future sexual addiction. This study might also help mental health professionals and developmental psychologists to formulate better methods to help prevent sexual addiction later in adulthood.

Parents need help engaging and discussing sexuality with their children in age-appropriate ways. The results from the present study could shape curriculum addressing the issues of sexual addiction and how one's family-of-origin could either positively or negatively influence future sexual addiction. Continued research could equip parents with better tools and knowledge as they address sexuality with their children.

In this study, sexual orientation was divided into three categories, including sexual activity, sexual attraction, and self-described sexual orientation. Each of these categories had a spectrum, with heterosexuality or the equivalent (e.g., totally attracted to opposite sex) on one end and gay or the equivalent (e.g., totally attracted to opposite sex) on the other end. Bisexuality or the equivalent was in the middle of the spectrum. An interesting pattern emerged, as bisexuality appeared to be more closely related to sexual addiction than heterosexuality or homosexuality. The results from this study showed a higher presence of sexual addiction as well as a history of sexual abuse among those who indicated that they were bisexual or those who had similar indicators under sexual orientation related to attraction and sexual activity. More research that explores this

dynamic may shed light on the topic of sexual addiction in general, as well as how it is related to sexual orientation.

Sexual abuse and sexual addiction were shown to have a strong association in the present study, a finding that was in line with the literature. Understanding the connection between sexual abuse and sexual addiction and exploring this in one's story as one recovers could help addicts to understand why they are dealing with their specific issues. Understanding this connection and working through this tragic part of one's story is important for the recovery process. Awareness of this association continually brings this awful societal reality to the forefront, enlightening the public about the need for parents and communities to prevent such terrible acts on the innocent.

Recommendations for Further Research

There were a number of areas where the present study highlighted the need for additional research. Future research using the *FSS-R* needs to explore whether there were better tests than the *SAST* to correlate with sexual addiction. There were a number of sexual addiction tests that may be used in future research with the *FSS-R*. Other tests related to sexual addiction may give a broader view of the impact that family-of-origin characteristics have on sexually addictive behavior. Some of the tests that should be considered include: *Sexual Dependency Inventory – Revised* (Carnes & Delmonico, 1997), *Garos Sexual Behavior Index* (Garos, 1996), *Internet Sex Screening Test* (Zapf, Greiner, & Carroll, 2008), *Hypersexual Behavior Consequences Scale* (Reid, Garos, & Fong, 2012), and *Internet Assessment: A Structured Interview for Assessing Problematic Online Sexual Behavior* (Delmonico & Griffin, 2005). These tests would need to be reviewed to see if they were applicable. The *Sexual Dependency Inventory – Revised*

(Carnes & Delmonico, 1997) is used to identify the extent of a subject's sexual addiction, so it would be a natural follow-up to the *SAST*. The *Garos Sexual Behavior Index* (Garos, 1996) could be used with either male or female adults. It measures the behavioral, affective, and cognitive constructs associated with sexual frequency and control disorders. The *Internet Sex Screening Test* (Zapf, Greiner, & Carroll, 2008) is used to measure sexual addiction and behavior on the Internet. The *Hypersexual Behavior Consequences Scale* (Reid, Garos, & Fong, 2012) assessed the various consequences of hypersexual behaviors reported by hypersexual patients. The *Internet Assessment: A Structured Interview for Assessing Problematic Online Sexual Behavior* (Delmonico & Griffin, 2005) is a structured interview, rather than a scale, that explored and assessed problematic online sexual behavior.

It would also be beneficial to correlate the variables from the present study with attachment theory (cf. Zapf et al., 2008). There appeared to be a strong overlap between the present study and attachment theory. More research is needed to see whether and to what extent this was the case. The ECR (*Experiences in Close Relationships*, 1998) is a test designed to assess individual differences with respect to attachment-related anxiety and attachment-related avoidance. This could be correlated with the *FSS-R* and *SAST* to better understand how a person's attachment style played a role in their sexual addiction and their family-of-origin dynamic.

More research is needed regarding the relationship between childhood sexual abuse and later adult sexual addiction. A related topic would be how the sexual abuse victims' family-of-origin handled the abuse and how it impacted the victim's sexuality and potential sexual addiction later in life.

More research is needed regarding the degree to which sexual addiction is correlated with bisexual men, as well as how it is correlated with heterosexual or gay men. Though the present study gave adequate results, a stronger sample of gay men would strengthen the research.

Research is needed to explore the extent and dynamics of sexual addiction in women. The *FSS-R* could be used, along with the *W-SAST* (Women's Sexual Addiction Screening Test), to understand the impact of family-of-origin dynamics surrounding sexuality in light of sexual addiction in women. The *W-SAST* was adapted from the original *SAST* in order to look specifically at sexual addiction in women. A test-retest on the *FSS-R* would be needed with a female population, as the *FSS-R* was originally tested with male participants. The *FSS-R* items were not gender specific, so the test could easily be adapted for female subjects.

More research is needed regarding the influence of family-of-origin variables on sexual addiction. Future research should explore whether there were important variables other than those found in the *FSS-R*.

The *FSS-R* could also be used to conduct other types of research (besides sexual addiction) that focus on the relationship between how sexuality was handled in one's family-of-origin and a new topic. Other topics of research might include the impact of the manner in which one's family-of-origin handled sexuality on partner/marital sexual problems and satisfaction, infidelity, and certain types of sexual behavior or fetishes. The *FSS-R* could also be used with other, more specific areas related to sexual addiction. Future research could also use the *FSS-R* to explore the relationship between how

sexuality was handled in one's family-of-origin and topics such as cybersex addiction, Internet pornography use, and men who frequent sex workers.

The present research did not explore the spiritual/religious backgrounds of the participants. This would be an important demographic variable in a similar future study in order to understand how this demographic variable was related to sexual addiction and the specific family-of-origin variables found in the *FSS-R*.

There was a limited amount of research that specifically addressed the relationship between one's family-of-origin and sexual addiction. The present study has attempted to address this gap, but more research is needed. The strong anecdotal evidence needed to be empirically confirmed, supported, or disputed. More research is needed to explore how these family-of-origin categories could be used in sexual addiction recovery.

Conclusion

According to Phillips (2006), many clinicians and researchers have proposed that family-of-origin characteristics influenced sexual addiction, but they did not show empirical validation for these views (see also Carnes, 1992; Laaser, 2002; Matheny, 2002). This study began to explain this influence by bolstering some of the anecdotal evidence. This study also filled research gaps and highlighted areas for future research in this area of study. The findings of this study broke new ground in the area of sexual addiction by showing how three variables related to a man's family-of-origin could have influenced men to sexual addiction in adulthood. The three variables (negative attitudes and communication about sexuality, exposure to sexual stimuli, and open sexual

discussion) were all related to sexual addiction in adult men. The present research has shown the *FSS-R* test to be a reliable instrument that could be used for future research.

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Table 1

First Test-Retest Reliability - Family Sexuality Scale (FSS)

	Test (Mean/SD)	Retest (Mean/SD)	<i>r</i>
FSS total score	179.91 (13.1)	179.84 (12.9)	0.78*
<i>FSS</i> Communication Openness Regarding Sexuality	56.44 (20.1)	43.38 (16.0)	0.88*
<i>FSS</i> Derogatory/Negative Communication Regarding Sexuality	64.78 (14.5)	64.38 (15.5)	0.89*
<i>FSS</i> Exposure to Sexual Stimuli	29.31 (10.4)	28.66 (10.1)	0.93*
<i>FSS</i> Age-inappropriate Family Sexual Communication	44.53 (5.4)	43.44 (5.7)	0.93*
<i>N</i> = 32 * <i>p</i> < .05			

Table 2

Characteristics of Study Participants (N = 374)

	Frequency (%)
Sex	
Male	374 (100%)
Current Age (years)	
Mean = 39.6	
Standard Deviation = 11.6	
Range = 20-76	
Ethnicity/Race	
African American	8 (2.1)
Asian American/Pacific Islander	5 (1.3)
Latino	4 (1.1)
Multi-racial	9 (2.4)
Native American	1 (0.3)
White	344 (92.0)
Other	3 (0.8)
Relational Status	
Single	43 (11.5)
Married/Partnered	304 (81.3)
Separated	6 (1.6)
Divorced	12 (3.2)
Widowed	1 (0.3)
Co-habitation	8 (2.1)
Educational Background	
No indication	1 (0.3)

GED or High school degree	21 (5.6)
Junior College Degree	11 (2.9)
Four-year College/University Degree	122 (32.6)
Graduate or Professional Degree	185 (49.5)
Doctorate Degree	34 (9.1)

Socioeconomic/Annual household income levels

Less than 19,999	21 (5.6)
20,000 – 34,999	43 (11.5)
35,000 – 49,999	55 (14.7)
50,000 – 64,999	54 (14.4)
65,000 – 79,999	47 (12.6)
80,000 – 99,999	55 (14.7)
100,000 and above	99 (26.5)

How would you define your sexual activity or behavior?

All sex with same sex	38 (10.2)
Mostly sex with same sex	3 (0.8)
More sex with same sex	4 (1.1)
Equally with both sexes	1 (0.3)
More sex with opposite sex	6 (1.6)
Mostly sex with opposite sex	14 (3.7)
All sex with opposite sex	286 (76.5)
Never had sex	22 (5.9)

How would you define your sexual attraction?

Totally attracted to same sex	35 (9.4)
Mostly attracted to same sex	10 (2.7)
More attracted to same sex	5 (1.3)
Equally attracted to both sexes	4 (1.1)
More attracted to opposite sex	6 (1.6)

Mostly attracted to opposite sex	23 (6.1)
Totally attracted to opposite sex	290 (77.5)
No indication	1 (0.3)

How would you define your sexual orientation?

Heterosexual	347 (92.8)
Gay	17 (4.5)
Bisexual	8 (2.1)
Other (Pansexual)	1 (0.3)
No indication	1 (0.3)

Were you sexually abused as a child or adolescent?

Yes	82 (21.9)
No	291 (77.8)

Table 3

FSS57 after oblique rotation Eigenvalue - Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings Total
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	
1	18.953	33.251	33.251	18.953	33.251	33.251	16.257
2	7.295	12.799	46.050	7.295	12.799	46.050	6.064
3	3.009	5.278	51.329	3.009	5.278	51.329	14.650
4	1.709	2.999	54.328	1.709	2.999	54.328	4.477
5	1.583	2.776	57.104	1.583	2.776	57.104	4.548
6	1.291	2.265	59.369				
7	1.252	2.196	61.565				
8	1.125	1.975	63.540				
9	1.092	1.916	65.456				
10	.994	1.744	67.200				
11	.955	1.675	68.875				
12	.893	1.567	70.442				
13	.840	1.473	71.915				
14	.803	1.408	73.323				
15	.785	1.377	74.700				
16	.743	1.303	76.003				
17	.701	1.229	77.232				
18	.666	1.169	78.400				
19	.646	1.133	79.534				
20	.627	1.099	80.633				
21	.586	1.028	81.661				
22	.568	.996	82.657				

23	.561	.984	83.641
24	.533	.935	84.575
25	.520	.913	85.488
26	.474	.832	86.321
27	.445	.781	87.102
28	.432	.757	87.859
29	.420	.737	88.597
30	.403	.707	89.304
31	.387	.679	89.983
32	.381	.668	90.651
33	.361	.633	91.284
34	.353	.620	91.904
35	.336	.589	92.493
36	.312	.548	93.041
37	.307	.538	93.580
38	.281	.492	94.072
39	.274	.481	94.553
40	.253	.445	94.998
41	.243	.426	95.424
42	.237	.416	95.839
43	.229	.402	96.241
44	.224	.392	96.634
45	.203	.356	96.989
46	.193	.339	97.329
47	.181	.317	97.646
48	.178	.312	97.958
49	.172	.301	98.259
50	.157	.275	98.534
51	.154	.270	98.804

52	.136	.239	99.043
53	.133	.233	99.276
54	.123	.215	99.492
55	.117	.205	99.696
56	.099	.173	99.870
57	.074	.130	100.000

Extraction Method: Principal Component Analysis.

Rotation Method: Oblimin with Kaiser Normalization.

Table 4

Factor Loadings for 3-factor structure

	Original Factor Loadings		
	1	2	3
<i>Factor 1: Open Sexual Discussion</i>			
28. In your family-of-origin, the viewing of pornography was addressed constructively and with respect.	.612		
9. In your family-of-origin, there was no freedom to express questions about issues related to sex during childhood and adolescence.	-.713		-.480
8. In your family-of-origin, the sexual effects of puberty were discussed.	-.721		
7. In your family-of-origin, the pleasure of sex was discussed.	-.728		-.489
3. In your family-of-origin, the topic of sexual intercourse was discussed.	-.783		-.320
2. In your family-of-origin, you felt comfortable talking about issues of sexuality.	-.789		-.438
30. In your family-of-origin, the discussion of sexuality was safe and affirming.	.789		.569
56. In your family-of-origin, there was age-appropriate teaching on human sexuality in the home.	-.814		-.429
10. In your family-of-origin, sex/sexuality were topics that were avoided.	-.816		-.492
13. In your family-of-origin, talking about issues of sexuality was off limits.	-.819		-.546

Factor 2: Exposure to Sexual Stimuli

40. In your family-of-origin, adult family members gave the impression (explicitly or implicitly) that it was wrong for children to see pornography.		.766
16. In your family-of-origin, the viewing of pornography was encouraged.		.677
46. In your family-of-origin, pornographic material was freely accessible in the home.		.641
43. In your family-of-origin, protection and rules were in place surrounding the issue of pornography in order to prevent any family member from accessing material (I.e. Computer filters, blocks on inappropriate TV programs, etc.)?		.587

Factor 3: Negative Attitudes and Communication About Sexuality

33. In your family-of-origin, sexuality was viewed as a shameful activity.	.521	.851
20. In your family-of-origin, sex/sexuality was seen as bad.	.565	.834
27. In your family-of-origin, sex/sexuality was viewed in a positive light.	.660	.787
23. In your family-of-origin, sex/sexuality was viewed as healthy.	.610	.783
34. In your family-of-origin, sex was seen as a good part of life to be enjoyed.	.632	.743
31. In your family-of-origin, children were shamed for discussing issues of sexuality.	.530	.732
26. In your family-of-origin, children were criticized for discussing issues of sexuality.	.477	.673
17. In your family-of-origin, people were responded to harshly for raising sexual topics.	.476	.623

Extraction Method: Principal Component Analysis
Rotation Method: Oblique

Table 5

Family Sexuality Scale - Original and Revised Scales

Original Scale		Revised Scale	
Name	N of items	Name	N of items
1. Derogatory/negative Communication Regarding Sexuality	19	1. Negative Attitudes and Communication About Sexuality	8
2. Exposure to Sexual Stimuli	12	2. Exposure to Sexual Stimuli	4
3. Communication Openness Regarding Sexuality	16	3. Open Sexual Discussion	10
4. Age-appropriateness of Sexual Communication	10		
Total	57	Total	22

Table 6

Family Sexuality Scale - Revised (FSS-R) Reliability Analysis-Internal Consistency

Subscale	Standardized Cronbach's	N of Items
	Alpha	
Negative Attitudes and Communication About Sexuality	.92	8
Exposure to Sexual Stimuli	.75	4
Open Sexual Discussion	.74	10

Table 7

Second Test-Retest Reliability - Family Sexuality Scale - Revised (FSS-R)

	Test (Mean/SD)	Retest (Mean/SD)	<i>r</i>
<i>FSS</i> total score	66.06 (6.9)	65.91 (6.39)	0.85*
<i>FSS</i> Open Sexual Discussion	31.66 (7.5)	32.34 (6.8)	0.94*
<i>FSS</i> Negative Attitudes and Communication About Sexuality	24.66 (6.5)	24.31 (6.9)	0.85*
<i>FSS</i> Exposure to Sexual Stimuli	9.75 (4.6)	9.25 (4.2)	0.92*

N = 32 **p* < .05

Table 8

Demographic Variables Sexual Addiction Screening Test (SAST) Results

	M	SD	N
Ethnicity/Race			
African American	13.1	6.5	8
Asian American/Pacific Islander	9.6	6.5	5
Latino	12.0	4.0	4
Multi-racial	10.2	5.7	9
White	10.4	5.6	344
Other	13.7	4.5	3
Relational Status			
Single	10.1	4.5	43
Married/partnered	10.3	5.8	304
Separated	15.7	4.6	6
Divorced	14.9	3.2	12
Cohabiting	6.9	3.1	8
Were you sexually abused as a child?			
Yes	13.29	4.99	82
No	9.64	5.53	291
How would you define your sexual activity or behavior?			
All sex with same sex	9.5	5.3	38
Mostly sex with same sex	20.0	1.0	3
More sex with same sex	16.0	3.8	4
Equally with both sexes	17.0	--	1
More sex with opposite sex	18.3	3.3	6
Mostly sex with opposite sex	13.5	5.3	14
All sex with opposite sex	10.0	5.6	286

Never had sex	11.1	4.3	22
How would you define your sexual attraction?			
Totally attracted to same sex	10.1	5.8	35
Mostly attracted to same sex	8.3	6.5	10
More attracted to same sex	15.6	2.6	5
Equally attracted to both sexes	11.0	6.5	4
More attracted to opposite sex	16.5	4.0	6
Mostly attracted to opposite sex	12.6	7.1	23
Totally attracted to opposite sex	10.2	5.4	290
How would you define your sexual orientation?			
Heterosexual	10.5	5.6	347
Gay	6.7	3.4	17
Bisexual	17.3	3.7	8
Educational background			
GED or high school degree	12.0	6.4	21
Junior college degree	13.9	6.3	11
Four-year college/university degree	11.2	5.9	122
Graduate or professional degree	9.8	5.2	185
Doctorate degree	9.1	5.5	34
Socioeconomic status			
Less than \$19,999	10.8	4.7	21
\$20,000-34,999	9.6	4.4	43
\$35,000-49,999	11.1	4.8	55
\$50,000-64,999	10.3	5.9	54
\$65,000-79,999	10.9	6.1	47
\$80,000-99,999	10.6	5.9	55
\$100,000 and above	10.2	6.1	99

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

Informed Consent

Dear Research Participant,

You are invited to participate in an online study conducted by Mark Pfuetze, MA, a doctoral student under the supervision of R. Rocco Cottone, PhD, a Professor at the University of Missouri-St. Louis. The purpose of this research is to examine how sexuality was handled in the family-of-origin of men who exhibit sexually addictive behavior.

Your participation will involve completing an anonymous online survey, which asks questions about how sexuality was handled in one's family-of-origin and one's sexually addictive behavior. We hope to collect data from about 230 adult men aged 18 years of age and older. As this is a web-based survey with unlimited geographic availability, there is the possibility of many more participants than originally anticipated.

The amount of time involved in your participation will be approximately 20-30 minutes. There may be certain risks or discomforts associated with this research. They may include uncomfortable feelings that might come from answering questions related to your experience with your family-of-origin and present and past sexual behaviors and thoughts. By participating in this study, you will help provide a voice to men dealing with and often struggling with sexually addictive behavior. Additionally, your participation will help mental health professionals better understand how to better help and treat men struggling with sexually addictive behavior.

Your participation is voluntary and you may choose not to participate in this research study or to withdraw your consent at any time. You may choose not to answer any questions that you are not comfortable responding to. You will NOT be penalized in any way should you choose not to participate or to withdraw.

By agreeing to participate, you understand and agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In all cases, your identity will not be revealed. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection). That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored on a password-protected computer and/or in a locked office. Your email address will not be associated with or connected to your survey responses.

If you have any questions or concerns regarding this study, or if any problems arise, you may email Mark Pfuetze, MA at mpfuetze@earthlink.net or R. Rocco Cottone, PhD at cottone@umsl.edu. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research Administration, at 314-516-5897.

By clicking on the Yes button for the first question below, you signify your consent to participate in this research project.

Thank you!

Mark and Dr. Cottone

Mark Pfuetze, MA
R. Rocco Cottone, PhD

University of Missouri-St. Louis

***1. I have read this consent form and have been given the opportunity to ask questions. I consent to my participation in the research described above.**

☐ Yes

☐ No

***2. Is your age currently 18 years old or older?**

☐ Yes

☐ No

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

***3. What is your age and date of birth (mm/yyyy)?**

***4. Gender:**

☐

Male

☐

Female

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

5. Ethnicity/race (check as many as apply)

- ☐ White
- ☐ African American
- ☐ Latino
- ☐ Native American
- ☐ Asian American/Pacific Islander
- ☐ Multi-racial
- ☐ Other

6. Relational Status:

- ☐ Single
- ☐ Married/Partnered
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Co-habitation

7. Educational Background:

- ☐ Less than 12 years
- ☐ GED or High school diploma
- ☐ Junior College Degree
- ☐ Four-year College / University Degree
- ☐ Graduate or Professional Degree
- ☐ Doctorate Degree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

8. Socioeconomic / Annual household income levels:

- ☐ Less than 19,999
- ☐ 20,000 – 34,999
- ☐ 35,000 – 49,999
- ☐ 50,000 – 64,999
- ☐ 65,000 – 79,999
- ☐ 80,000 – 99,999
- ☐ 100,000 and above

9. How would you define your sexual activity or behavior?

- ☐ All sex with same sex
- ☐ Mostly sex with same sex
- ☐ More sex with same sex
- ☐ Equally with both sexes
- ☐ More sex with opposite sex
- ☐ Mostly sex with opposite sex
- ☐ All sex with opposite sex
- ☐ Never had sex

10. How would you define your sexual attraction?

- ☐ Totally attracted to same sex
- ☐ Mostly attracted to same sex
- ☐ More attracted to same sex
- ☐ Equally attracted to both sexes
- ☐ More attracted to opposite sex
- ☐ Mostly attracted to opposite sex
- ☐ Totally attracted to opposite sex

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

11. How would you define your sexual orientation?

☐

Gay

☐

Bisexual

☐

Heterosexual

Other (please specify)

12. In your family-of-origin, through childhood and adolescence you were allowed to express views to other family members related to your sexuality?

☐

Strongly disagree

☐

Disagree

☐

Moderately disagree

☐

Moderately agree

☐

Agree

☐

Strongly agree

13. In your family-of-origin, you felt comfortable talking about issues of sexuality?

☐

Strongly disagree

☐

Disagree

☐

Moderately disagree

☐

Moderately agree

☐

Agree

☐

Strongly agree

14. In your family-of-origin, the topic of sexual intercourse was discussed?

☐

Strongly disagree

☐

Disagree

☐

Moderately disagree

☐

Moderately agree

☐

Agree

☐

Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

15. In your family-of-origin, if the discussion of sexuality occurred, it created tension and discomfort?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

16. In your family-of-origin, sex/sexuality was discussed as a good, natural, and healthy part of life?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

17. In your family-of-origin, the topic of masturbation was discussed?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

18. In your family-of-origin, the pleasure of sex was discussed?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

19. In your family-of-origin, the sexual effects of puberty were discussed?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

20. In your family-of-origin, there was no freedom to express questions about issues related to sex during childhood and adolescence?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

21. In your family-of-origin, sex/sexuality were topics that were avoided?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

22. In your family-of-origin, the topic of masturbation was ignored?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

23. In your family-of-origin, the topic of sex/sexuality created extreme discomfort in oneself?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

24. In your family-of-origin, talking about issues of sexuality was off limits?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

25. In your family-of-origin, the issue of pornography was avoided?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

26. In your family-of-origin, the topic of sexual intercourse was avoided?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

27. In your family-of-origin, the viewing of pornography was encouraged?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

28. In your family-of-origin, people were responded to harshly for raising sexual topics?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

29. In your family-of-origin, sexuality was seen as "dirty?"

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

30. In your family-of-origin, masturbation was viewed as unnatural or a sin?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

31. In your family-of-origin, sex/sexuality was seen as bad?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

32. In your family-of-origin, sexuality was age-appropriately discussed in safe and non-shameful ways?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

33. In your family-of-origin, sex/sexuality was viewed as a “good thing”?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

34. In your family-of-origin, sex/sexuality was viewed as healthy?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

35. In your family-of-origin, sex/sexuality was seen as wrong?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

36. In your family-of-origin, sex/sexuality was viewed as natural?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

37. In your family-of-origin, children were criticized for discussing issues of sexuality?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

38. In your family-of-origin, sex/sexuality was viewed in a positive light?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

39. In your family-of-origin, the viewing of pornography was addressed constructively and with respect?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

40. In your family-of-origin, masturbation was viewed as normal?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

41. In your family-of-origin, the discussion of sexuality was safe and affirming?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

42. In your family-of-origin, children were shamed for discussing issues of sexuality?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

43. In your family-of-origin, negative comments were made about women who appeared "sexy"?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

44. In your family-of-origin, sexuality was viewed as a shameful activity?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

45. In your family-of-origin, sex was seen as a good part of life to be enjoyed?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

46. In your family-of-origin, male sexuality was viewed as a normal part of being a man?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

47. In your family-of-origin, sexual scenes on TV were met with channel changing?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

48. In your family-of-origin, adult family members freely walked around the home in sexually provocative undergarments?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

49. In your family-of-origin, pornography was inaccessible in the home?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

50. In your family-of-origin, privacy, especially around sexuality, was granted and respected?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

51. In your family-of-origin, adult family members gave the impression (explicitly or implicitly) that it was wrong for children to see pornography?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

52. In your family-of-origin, adult family members gave the impression (explicitly or implicitly) that it was OK if their children engaged in sexual activities?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

53. In your family-of-origin, boundaries surrounding one's body and sexuality were highly encouraged?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

54. In your family-of-origin, protection and rules were in place surrounding the issue of pornography in order to prevent any family member from accessing material (I.e. Computer filters, blocks on inappropriate TV programs, etc.)?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

55. In your family-of-origin, sexual jokes were frequently shared and enjoyed?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

56. In your family-of-origin, pornographic materials and/or videos were commonly viewed in shared space in the home?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

57. In your family-of-origin, pornographic material was freely accessible in the home?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

58. In your family-of-origin, children were protected from seeing adult family members having intercourse?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

59. In your family-of-origin, the issue of sexuality was discussed in ways that were age-appropriate?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

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60. In your family-of-origin, exposure to pornography before the age of 14 years old was not considered a problem?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

61. In your family-of-origin, adult sexual topics were not discussed with children before the age of 14 years old?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

62. In your family-of-origin, the family did not prevent children under the age of 14 years old from seeing sexual activities?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

63. In your family-of-origin, the family protected children under the age of 14 years old from participating in sexual activities?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

64. In your family-of-origin, children under the age of 14 years old were encouraged to be sexually active?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

65. In your family-of-origin, sexual contact was a common theme displayed in the presence of children under the age of 14 years old?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

66. In your family-of-origin, the topic and potential problems of pornography were discussed with children under the age of 14 years old?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

67. In your family-of-origin, there was age-appropriate teaching on human sexuality in the home?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

68. In your family-of-origin, the problem of adults touching the genitals of pre-teens was discussed?

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Moderately disagree
- ☐ Moderately agree
- ☐ Agree
- ☐ Strongly agree

69. Were you sexually abused as a child or adolescent?

- ☐ Yes
- ☐ No

70. Do you regularly purchase romance novels or sexually explicit magazines?

- ☐ Yes
- ☐ No

Family Sexuality Scale, Sexual Addiction Screening Test, Informed

71. Have you stayed in romantic relationships after they become emotionally or physically abusive?

☐ Yes

☐ No

72. Do you often find yourself preoccupied with sexual thoughts or romantic daydreams?

☐ Yes

☐ No

73. Do you feel that your sexual behavior isn't normal?

☐ Yes

☐ No

74. Does your spouse (or significant other(s)) ever worry or complain about your sexual behavior?

☐ Yes

☐ No

75. Do you have trouble stopping your sexual behavior when you know it is inappropriate?

☐ Yes

☐ No

76. Do you ever feel bad about your sexual behavior?

☐ Yes

☐ No

77. Has your sexual behavior ever created problems for you and your family?

☐ Yes

☐ No

78. Have you ever sought help for sexual behavior you didn't like?

☐ Yes

☐ No

79. Have you ever worried about people finding out about your sexual activities?

☐ Yes

☐ No

80. Has anyone been hurt emotionally because of your sexual behavior?

☐ Yes

☐ No

81. Have you ever participated in sexual activity in exchange for money or gifts?

☐ Yes

☐ No

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82. Do you have times when you act out sexually followed by periods of celibacy (no sex at all)?

☐ Yes

☐ No

83. Have you made efforts to quit a type of sexual activity and failed?

☐ Yes

☐ No

84. Do you hide some of your sexual behavior from others?

☐ Yes

☐ No

85. Do you find yourself having multiple romantic relationships at the same time?

☐ Yes

☐ No

86. Have you ever felt degraded by your sexual behavior?

☐ Yes

☐ No

87. Has sex or romantic fantasies been a way for you to escape your problems?

☐ Yes

☐ No

88. When you have sex, do you feel depressed afterwards?

☐ Yes

☐ No

89. Do you regularly engage in sadomasochistic behavior?

☐ Yes

☐ No

90. Has your sexual activity interfered with your family life?

☐ Yes

☐ No

91. Have you been sexual with minors?

☐ Yes

☐ No

92. Do you feel controlled by your sexual desire or fantasies of romance?

☐ Yes

☐ No

93. Do you ever think your sexual desire is stronger than you are?

☐ Yes

☐ No



Office of Research Administration

One University Boulevard
St. Louis, Missouri 63121-4499
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DATE: June 6, 2013

TO: Mark Pfuetze, MAC
FROM: University of Missouri-St. Louis IRB

PROJECT TITLE: [446117-3] Family-of-origin Characteristics of Men Who Engage Regularly with Sexually Addictive Behavior

REFERENCE #:

SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED

APPROVAL DATE: June 5, 2013

EXPIRATION DATE: June 5, 2014

REVIEW TYPE: Full Committee Review

This proposal was approved by the University of Missouri-St. Louis IRB for a period of one year starting from the date listed above. The University of Missouri-St. Louis IRB must be notified in writing prior to major changes in the approved protocol. Examples of major changes are the addition of research sites or research instruments.

An annual report must be filed with the committee. This report should indicate the starting date of the project and the number of subjects since the start of project, or since last annual report.

Any consent or assent forms must be signed in duplicate and a copy provided to the subject. The principal investigator is required to retain the other copy of the signed consent form for at least three years following the completion of the research activity and the forms must be available for inspection if there is an official review of the UM-St. Louis human subjects research proceedings by the U.S. Department of Health and Human Services Office for Protection from Research Risks.

This action is officially recorded in the minutes of the committee.

If you have any questions, please contact Carl Bassi at 314-516-6029 or bassi@umsl.edu. Please include your project title and reference number in all correspondence with this committee.



Office of Research Administration

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DATE: June 5, 2013

TO: Mark Pfuetze
FROM: University of Missouri-St. Louis IRB

PROJECT TITLE: [450529-2] Test-Retest Reliability Analysis of the Family Sexuality Scale
REFERENCE #:
SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED
APPROVAL DATE: June 5, 2013
EXPIRATION DATE: June 5, 2014
REVIEW TYPE: Full Committee Review

This proposal was approved by the University of Missouri-St. Louis IRB for a period of one year starting from the date listed above. The University of Missouri-St. Louis IRB must be notified in writing prior to major changes in the approved protocol. Examples of major changes are the addition of research sites or research instruments.

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