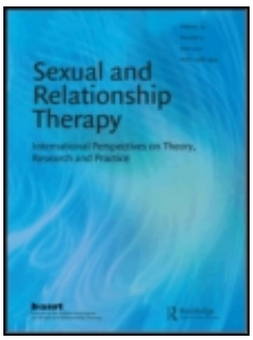

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CLINICAL UPDATE

A group model for the treatment of problematic Internet related sexual behaviours

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ABSTRACT *Problematic Internet related sexual behaviours do not reflect a discrete disorder but, rather, a new range of behaviours made increasingly possible and accessible by the advent of Internet technology. Men seeking treatment for sexual compulsivity, impulsivity or hypersexuality often report Internet related behaviours. For some the Internet is the primary venue for problematic behaviour; for others it is one of many venues. In either case, treatment efforts need to include an emphasis on identifying and modifying the role of the Internet in the development and maintenance of problematic sexual functioning. This article describes an outpatient group treatment model for problematic sexual behaviours, including those that are Internet related. The author presents a rationale for the integration of systemic and cognitive behavioural frameworks and describes the components of the group treatment process.*

KEYWORDS: *Internet; sexual behaviours; compulsivity.*

Introduction

Literature expanding our understanding of problematic Internet related sexual behaviours is just beginning to emerge (Binik, 2001; Griffiths, 2001). Clinicians are drawing on literature regarding eating disorders (Orzack & Ross, 2000), addictive disorders (Orzack & Ross, 2000), the paraphilias and sex offender treatment (Galbreath *et al.*, 2002) to formulate treatment approaches (Line & Cooper, 2002; Galbreath *et al.*, 2002). This article describes an outpatient group treatment model for problematic Internet related sexual behaviours. The model is based on an integration of cognitive-behavioural and differentiation based systems theory. There has been a good deal of literature describing the effectiveness of cognitive behavioural group treatment for behavioural disorders (Galbreath *et al.*, 2002; Line & Cooper, 2002). It provides practical and immediate interventions that promote behavioural control and

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the development of self-management strategies. Differentiation based systems theory, as formulated by the late Murray Bowen, MD, provides an overarching lens through which both pathology and treatment progress are observed and interpreted (Kerr & Bowen, 1988). The author's integration of differentiation theory stems from an interest in maximizing long term treatment success through methods that go beyond behavioural control to promote change at an individual's basic level of emotional functioning.

Sexual compulsions are a heterogeneous group of behaviours that include but are not limited to problematic Internet related sexual behaviours. While Internet related sexual behaviour may be the primary problem for some, it often is only one among many categories of sexual behaviour targeted in treatment. For example, while a few men report no history of problematic sexual behaviour prior to their exposure to the Internet, others have an extensive history of other forms of sexual compulsivity. And while Internet sexual behaviour may be the preferred or only outlet for some, for others it may be one aspect of an extensive repertoire of sexual behaviours that have become problematic. The primary criteria for group membership is engagement in sexual behaviour that is experienced as excessive, out of control, preoccupying, egodystonic or disruptive of a valued relationship or other life domain(s). This may include:

- Paraphilic sexual behaviours.
- Non-paraphilic sexual behaviours such as masturbation, serial affairs, promiscuity, phone sex, use of prostitutes, massage parlours, 'swinging' clubs, strip clubs, etc.
- Use of non-Internet related pornography.
- Use of the Internet to access or transmit pornography.
- Use of the Internet to access sex partners or interactive sexual activity, whether limited to the Internet or evolving into face to face encounters.
- Diverse combinations of the above.

This programme is based on the assumption that Internet related sexual behaviours do not in themselves reflect a discrete disease process. Rather, they reflect the broad range of behaviours that were made increasingly possible or accessible by the advent of Internet technology. Internet related sexual behaviours are no different in their treatment implications than other problematic sexual behaviours commonly seen in sexual disorders clinics.

The absence of empirically based knowledge

The debate over whether any one conceptualization of problematic sexual behaviours is superior to another remains to be resolved through empirical methods (Moser, 1993; Stein *et al.*, 2000, 2001; Griffiths, 2001). Conceptual frameworks offered in the literature include addiction (Goodman, 1993; Schneider, 1994, 2000; Mahorney, 2002), OCD spectrum (Quadland, 1985), impulse control disorder (Barth & Kinder, 1987), paraphilia-related disorders and hypersexuality (Kafka, 1994). In the author's observation, problematic sexual behaviours reflect varied, not identical, underlying

mechanisms. Terms such as 'cybersex addiction' imply erroneously that we have empirical evidence that an addiction framework applies most accurately to all patients and that the problematic behaviours reflect a singular discrete disease process. Until such evidence exists, it is logical to treat Internet related behaviours as just that—behaviours that are problematic in a patient's life. Treatment focuses on stopping problematic behaviours and ameliorating or managing the underlying mechanisms and vulnerabilities that drive the behaviour.

In addition to a lack of conceptual consensus, there have been no reports of controlled studies documenting the short or long term effectiveness of any psychotherapeutic model for treating problematic Internet and non-Internet related sexual behaviours. The phenomenon of Internet related sex represents a still new phenomenon that awaits an empirical basis both conceptually and interventionally.

Comprehensive treatment programme structure

Most often, group treatment is only one aspect of a larger treatment plan that includes multiple components. Men with comorbid conditions such as bipolar disorder, major depression, or a debilitating Axis II condition obviously demand a more comprehensive treatment package than a time-limited group can offer. At the same time, if the other relevant resources are in place, group treatment may be an extremely beneficial component of their total care. A primary benefit of group treatment is that the group accommodates the vast range of expressions of sexual behaviour and diverse driving mechanisms. The men benefit as much from discerning their differences as they do their similarities.

The comprehensive treatment programme structure includes the following components:

Assessment

The treatment format described here assumes that a comprehensive psychiatric/psychosexual assessment and risk assessment have been conducted, an accurate multiaxial diagnosis and problem formulation developed, and a treatment plan informed by these generated for each patient. In the author's programme, all patients undergo an extensive diagnostic interviews and complete several psychometric inventories that assess personality factors, acute psychiatric symptoms, sexual functioning within a primary relationship, substance use or abuse, sexual orientation, current and past pornography use, hypersexuality, and sexual compulsivity—including both Internet and non-Internet related sexual behaviours. The psychometric measures completed by the patient are used as pre and post treatment markers of change.

Individual psychotherapy

Individual psychotherapy is conducted as indicated, with the goals of stabilizing the patient and promoting readiness for group participation. Some men benefit from more in depth individual work before beginning group, while others proceed into

group directly from the assessment. Men with significant co-morbid disorders, those with limited insight, or those carrying legal burdens may require regular individual sessions concurrently with participation in group. Some benefit from individual sessions scheduled the day after the group session in order to processing what occurred in group and have assistance in translating the group experience into self-relevant meaning.

Couple/marital psychotherapy

Couple/marital therapy is provided as indicated in order to stabilize the relationship, provide support to an impacted spouse or partner, to process and ameliorate the negative impact of the behaviour on the relationship, to re-establish healthy emotional and erotic intimacy, and to process the impact on the marriage of changes made by the patient as treatment progresses.

Group psychotherapy

The group treatment component is the core component of the programme and consists of 24 weekly sessions, $1\frac{1}{2}$ hours in length.

Psychopharmacology

A majority of the patients in the author's treatment programme are also treated with an SSRI medication, some with anxiolytics, mood stabilizers, and a few with antipsychotic medication. In cases involving risk to children, repeated relapse with high risk repercussions, or excessively high sexual drive, antiandrogenic medication is considered.

Follow-up/relapse prevention

Members who meet their treatment goals during the 24-week group component proceed into the follow-up or relapse prevention component. The follow-up group meets once monthly for $1\frac{1}{2}$ hours. The critical nature of this component cannot be overemphasized. Relapse is an ever-present risk, and the author has observed a clear relationship between long term success and participation in an ongoing support structure. Men who have participated in the 24 week group treatment programme are encouraged to participate in the follow-up group programme indefinitely.

Differentiation theory

Differentiation is defined as the ability to be emotionally connected with others while remaining autonomous in one's emotional functioning (Kerr *et al.*, 1988). Autonomous emotional functioning is characterized by a number of skills, including the ability to consciously mediate feelings with rational thought, to define one's self clearly and separately from others, and to act from that clarity in the face of pressure to please or conform.

Schnarch has described the therapist's ability to intervene from her own differentiated position—to be simultaneously highly invested in the therapeutic process and emotionally nonreactive—as the primary requisite skill (Schnarch, 1991). The therapist mediates group interaction so as to promote self-definition and dissuade behaviours that reflect either the patient's conformity to or defensive reaction to perceived 'correct' behaviours expected by, engaged in or suggested by the other group members or the therapist. The details of this therapeutic stance, especially as it is integrated into a framework that promotes specific behavioural and cognitive change, are complex and not within the scope of this article. However, a few implications are worth noting:

(1) All interventions are intended to increase each member's level of differentiation. This demands that patients remain free to make their own choices. While the therapist may well believe she knows what the patient needs to do to be healthy, her role is to support the patient in making his own decisions, even when those decisions are at odds with the expert notion of what is best. Neither compliance nor defensive resistance will promote differentiation or meaningful internalization of new ways of thinking and behaving. All interventions must invite self-definition, not other-definition.
(2) While the group is highly structured, members have a choice regarding the extent to which they partake of the resources offered. For example, the group begins with a weekly check-in, but the act of actually checking in is optional. The potential repercussions of not doing so are obvious. Nevertheless, the therapeutic stance of inviting but not requiring a check-in challenges members to examine their own internal blocks to self-disclosure and to witness their interactional deficits in action. This restrained stance guides the therapist's interventions throughout.
(3) The therapist models and invites restraint in group members regarding offering unsolicited feedback to others. This distinguishes the group model from more 'process oriented' groups in which unencumbered sharing and confrontation is encouraged. Here, members are encouraged to define if they want feedback at all, and if so, what kind will be most helpful to their recovery. Initially, many find this task difficult, awkward, confusing or anxiety producing. It may be counter to their past experiences as men to ask directly for their own needs, in particular emotional needs, to be met, especially by other men.

Group therapy goals

The overarching goals of this group model include:

- Elimination of maladaptive sexual behaviours.
- Identification of emotional, physiological, cognitive, behavioural and environmental triggers, and development of skills to manage them.

- Development of awareness of sexual urges and feelings and development of skills to manage them.
- Identification and correction of cognitive distortions related to the problem behaviour.
- Development of ability to identify and distinguish one's own thoughts, feelings and urges.
- Development of ability to mediate emotional and sexual feelings and urges with rational thought and deliberate behaviour.
- Restoration of integrity.
- Relapse prevention.

Group Stages

The life of the 24-week group progresses in three natural and roughly equal stages:

Stopping the target behaviour and learning strategies that support abstinence from the behaviour

The task of stopping the target behaviours can be challenging. Many have already stopped the behaviour in response to the crisis of having been discovered by a partner or spouse, of having lost a job or having been arrested. In these cases, the men may require help in understanding that the behaviour has stopped because of external pressures, not because of the sudden development of skills in self-management. At some point the external pressures will resolve, with the risk of relapse high unless the source of motivation has shifted from external to internal. Many men are fooled by this experience, assuming that the loss of desire to engage in the behaviour, and often the loss of fantasies and preoccupation, indicate that the problem is resolved. While helpful in maintaining abstinence initially, this 'gun at the back of your head' experience will not likely serve as a long term motivator, and may be an obstacle to the tasks of early treatment. For some men, it is not until their libido, the urge to engage in the problem behaviour, or related fantasies return that they can learn the skills of *resisting* and *managing* their sexual desire, problematic urges and fantasies. This dilemma inevitable emerges and is discussed openly in the early stages of the group. The men are challenged to observe and track their sexual drive, problematic urges and fantasies, and to disclose to the group if and when these temporarily fear-blocked phenomena reappear.

Identifying and managing triggers, affect, sexual drive, fantasies and urges

Triggers are defined as factors that increase the odds of the problematic behaviour occurring. Triggers may be feeling states such as anger, anxiety, loneliness or boredom. They may be thought distortions that promote the common defenses of minimization, denial and rationalization. Triggers may also be external factors in the environment, such as high risk situations, locations where problematic behaviours have been enacted in the past, or seemingly benign behaviours that nevertheless fuel the urge to engage in the problematic behaviour.

For example, one member identified that although he had stopped interacting with women on the Internet, he was reading the personal ads in the newspaper on a daily basis, and getting a small but undeniable sexual 'kick' from reading the ads. When he understood that reading the personal ads was sustaining a subtle level of sexual preoccupation, fueling his desire to act out sexually, and requiring another secret from his spouse, he made a commitment to stop.

In learning about triggers, men learn about and deconstruct the repeating cycle of feelings, thoughts, arousal and behaviour that generates and maintains the problem. They learn strategies for the rational mediation of primitive emotional and sexual urges. Insight into the cycle of destructive behaviour is not easily achieved until the target behaviour is stopped and behavioural control has been achieved to some degree. Only when the patient stops engaging in the behaviour does he have the opportunity to examine his feelings, thoughts and choices when the urge or temptation to engage emerges. This is the core of the work in the middle phase of treatment.

Each member is challenged to make his own decisions regarding complete or partial abstinence from trigger behaviours and situations. Some men make a commitment to no computer use at all. Others may be unable to do so and maintain their employment. Some make a commitment to no Internet use at all, or no Internet use at home, or no Internet use except when in full view of others. Some may give up all forms of pornography, while others may not. The question of abstinence or degree of abstinence from any particular behaviour is best managed on an individual case by case basis. Behavioural abstinence is nearly always no more than a starting point at best. The real work of recovery comes in the form of challenging one's basic level of emotional functioning by learning to identify and mediate the primitive feeling states and distorted thoughts that drive problem behaviour. Some of these 'triggers' are best if given up entirely and permanently; others may be engaged in to some degree by some people without inviting regression.

For most people, making these determinations is the work of a life time, and for which group psychotherapy helps lay the foundation. One task for many of the men, in the process of restoring integrity, is acknowledging continuing ambivalence about the prospect of giving up the behaviour forever. For the short term, they are able to make a clear commitment. At the same time, they are uncertain whether a life in which they never again experience the excitement and sexual intensity that accompanied their problem behaviour, regardless of its destructive impact on their lives, is something they can accomplish.

Exploring and ameliorating underlying contributing factors

The content of therapeutic work during the latter phase of group is varied, but commonly includes family of origin, marital, and career issues, trauma, dominant beliefs and attitudes, masculinity, assertiveness and passivity, dependency, aggression and anger management. Members are not encouraged to spend significant time on these issues until behavioural control and an understanding of and ability to manage triggers and affect have been accomplished to a significant degree. Men who are angry or in a relationship crisis have particular difficulty in

maintaining a focus on themselves and their own behaviour. If so, individual and/or couple sessions are in order so that these issues don't become ongoing obstacles to individual progress.

By the final phase of the group, most men have assumed full personal responsibility for their behaviour and can talk about the problems in their relationships without regressing to blaming their wives or partners. A common theme regarding relationships in the final group phase is sexuality and the compartmentalization many of the men have experienced—with routine, predictable or boring marital sex on the one hand, and a risqué adventuresome quality to their online sex on the other. Understanding this split and making decisions about deepening the intimacy, meaning and sexual satisfaction in their primary relationship is an important challenge that many of the men confront in the latter phase of group.

One group member, during the final phase of group, apologized to the group for his frequent absences and limited participation. He acknowledged that this reflected a familiar way of coping for him historically, and that it was related to depression, self-hatred, shame, expectations that others will disappoint him if he gets close to them, and, most significantly, compensatory feelings of entitlement and superiority, used in this case to convince himself that he was different, less pathological, and less needy than the other men. It was late in the group that he dropped this stance of distance and began to engage more meaningfully. His deepest work began just as the group neared its end point, and he agreed to repeat the 24-week group programme rather than proceed into the follow-up group.

Weekly group structure

The weekly group experience follows a logical order:

Completion of the SBCU behaviours questionnaire

Each week the men are asked to arrive a few minutes early in order to complete a questionnaire that tracks their engagement in their defined target problem behaviour in the prior week, their engagement in 'trigger' behaviours, masturbation frequency, partnered sex frequency, and the intensity of both problematic and healthy sexual urges, fantasies and thoughts. The questionnaire is confidential and only shared with the group if the member himself decides to do so, but is often a spring board to more in-depth therapeutic work.

Check-in

The therapist opens each group session with the question 'Who would like to check-in?' Members are invited, but not required, to make brief reports about their successes and difficulties in managing their target problem behaviour and triggers during the prior week, pertinent new awarenesses, significant events within a primary relationship, and relevant issues at work. No feedback is offered during check-in, although questions may be asked for clarification.

Therapeutic work

During this core portion of the group experience the men engage in one-on-one therapeutic dialogue with the therapist. This may be described as individual psychotherapy in the context of a group. The therapist begins this component with the question 'Who wants time for work tonight?' or 'John and Mike, you each stated during check-in that you would like some time tonight. Does anyone else want time?' The therapist is responsible for monitoring and structuring the time during this phase, and leaving time for feedback, interaction and group closure.

While a member works individually with the therapist, there are no interruptions by other group members unless invited by the member engaged in work. The other men learn to view this as an opportunity to learn more about themselves by witnessing the work of others.

When a member's work draws to a close, the therapist asks 'Would you like some feedback from the others? If so, what kind of feedback would be most helpful?' By the 24-week mark, many men have gained a new comfort and skill in this type of interaction. Further, many report engaging in this kind of interaction in their primary relationships and feeling more competent in responding to the needs of their partners or spouses. While it rarely occurs, a member has the right to ask that no feedback be offered. Occasionally, a member decides that he prefers to not have his own new thoughts, feelings or awarenesses interrupted by others' thoughts or questions.

The content of members' therapeutic work varies. While the therapist takes responsibility for critical topics being addressed, most of the relevant topics emerge naturally, and commonly include:

- Sharing one's sexual history and the details of the targeted problem behaviour. Sharing these details breaks the secrecy commonly associated with the problem behaviour. All members are encouraged to engage in this exercise, although not all are able or willing to do this fully in the early stages of the group.
- Identifying and resolving feelings of shame associated with the presenting problem. The men are assisted in understanding the benefits of remorse and regret and the potentially destructive impact of shame and unrelenting guilt, and in defining behavioural change that reflects their new understanding.
- Determining what it means in specific behavioural and relational terms to take full responsibility for the problem.
- Understanding, coping with and managing one's own response to a spouse's, partner's or other significant family members' anger regarding the problem behaviour.
- Learning to manage one's sexual drive in ways that are adaptive rather than compulsive, impulsive or otherwise harmful to self or others.
- Identifying and resolving blocks to feeling empathy for victims of the problem sexual behaviour. This includes making behavioural change in order to express empathy to significant others who have been impacted by the problem. Empathy is not viewed as synonymous with making an apology to those who have been hurt or feel betrayed. The question of apologizing is a complex one

and is answered by each man individually. If and when an apology is made, the member is challenged to do so from a position of integrity and differentiation, rather than from a position of defeatedness, shame and self-hatred, or of compliance with what he believes is expected by others.

- Resolving social isolation. In some cases, where underlying severe personality adaptations fuel isolation, this may take many months to resolve even to a small degree, but the group experience offers a meaningful opportunity to challenge the anxiety and interactional deficits that lead to isolation. Even small changes in the degree of isolation may have significant therapeutic benefit.
- Beliefs and assumptions regarding masculinity.
- Identifying and resolving to whatever extent possible marital and family of origin issues related to the problem behaviour. This may include issues of childhood loss or trauma. The men are discouraged from engaging deeply in this work in the initial stages of group, when the achievement of behavioural control and assumption of full responsibility for the problem are the most critical issues. Consistent with differentiation theory, the men are more likely to work through these kinds of issues in a meaningful way when their basic level of emotional functioning has improved.
- Identifying and resolving to whatever extent possible other related issues such as anger and anger management or issues of grief or loss. These issues are also best tackled in the latter stages of the group. However, in cases where a member is in the process of losing his marriage due to his sexual behaviours, issues of grief and loss will inevitably need to be addressed throughout the group process.
- Defining sexual health in one's own life and deciding what kinds of changes need to be made in terms of sexual repertoire and sexual style in order to promote sexual health and vitality in a primary relationship. This is a complex issue for most of the men, who often lead double lives—one in a primary relationship where sex is routine, predictable or boring, and one related to the more exciting or intense sex experienced secretly when engaging in the problem behaviour. Abandoning this and pushing the sexual and intimacy limits of their primary relationship can be profoundly growthful. At the same time, this must not be construed as an opportunity to resume some aspect of the sexually compulsive behaviour. This is a complex topic for the later stages of the group for most men, and is addressed more fully in conjoint treatment with a spouse or partner.

Feedback

As stated earlier, when a member asks for time to do therapeutic work, he works one-on-one with the therapist as the other members examine themselves while witnessing the member's work. When the work draws to a close, he is invited by the therapist to consider asking the other members for some form of feedback. This might take the form of supportive or confrontational comments, questions for clarification, or statements regarding how the member's work impacted other members. Learning to

ask for personally relevant feedback is a significant task for most of the men, few of whom have been socialized to be aware of their emotional needs or to ask directly for help. Some men find it more comfortable to confront than to offer support, so learning to refrain from interrupting another's work to offer opinions or advice is often a challenging task in the early stages of the group.

While interaction between members does not occur in the same form or free manner as in therapeutic groups that are more group process oriented, the interaction that emerges when a member requests feedback can be therapeutically rich. Similarly, the experience of carefully defining what one needs and wants from others can have useful relevance in real life relationships outside of group.

Behavioural contracting/group session closure

Each group session ends with the therapist inviting members to identify how the group session has impacted them and to define what they might want to take with them in the form of issues to think further about, or behavioural changes to which they might want to commit. Consistent with the therapeutic stance already described, the therapist poses some approximation of the following to the members: 'Think a moment about the work you have done tonight, either out loud or silently while witnessing others' work. Take a minute to assess how tonight's session has impacted you, what new thoughts you have, any feelings that have been stirred in you, and what relevance tonight's group has for your own recovery. You might make a mental, or written, note of anything you want to think or talk more about, anything that is confusing to you, or anything that seems new or important. Finally, think about the week ahead and what specific behaviours you want to be engaging in or not be engaging in to promote your own recovery. If you would like to make a commitment out loud, to let the rest of us know what you will be doing between now and when we see you again, please do so.'

In the early stage of group, there may be awkward silence in response to this challenge. If so, the therapist encourages the men to talk about what is difficult about the question or what the obstacles are to defining a commitment for change. By the final stages of the group, however, the men are generally eagerly responding to the task. This then becomes the starting point for the check-in the next week, when they share with the group progress made or difficulties discovered. If a member consistently does not participate in the behavioural contracting protocol, or forgets from week to week what he contracted for the preceding week, a therapeutic intervention will be in order, such as 'Joe, we've been meeting four weeks now and you have not participated in the contracting. You are in no way obligated to do so, but if you would like to be doing this, is there some way we can help you in getting started? Would it be useful to take some time to talk about why you have not made any contracts for change?' This may lead the member to disclose that he is confused and does not know what he should be working on. When this is identified, the therapist can invite the member to take some time at the next session to remove whatever obstacles are in the way. The next week, the therapist may begin the work section of the group with an invitation to Joe, 'I recall your saying last week that you have been confused

about how to get started in making concrete change at home. Is that something you want help with tonight or would you rather wait?' When asking this type of question, it's imperative that the therapist be neutral about expecting any particular response, and open to the possibility that the member is not ready to do the work.

The meaning of restoring integrity

Schnarch has discussed integrity as a manifestation of differentiation and a fundamental aspect of sexual intimacy (Schnarch, 1991). Self-forgiveness, self-acceptance, the capacity to interrupt and replace powerful feelings with rational thought, and the capacity to use in-the moment intentionality to abandon highly arousing and gratifying urges—all of these both require and reflect differentiation, self-mastery and autonomous functioning.

Many of the men, at the point they enter treatment, do not display integrity. They typically are operating from a defensive base and may even display antisocial features. It is the author's observation that this absence of integrity reflects, for most of the men, not an underlying anti-social template, but, rather, the diminishing effects of the problematic behaviour on the individual's functioning. As treatment proceeds, if the men respond to the challenge not simply to control behaviour and comply with expectations, but to improve their basic level of emotional functioning, integrity is restored.

Final thoughts

This article, like others to date that address problematic Internet and non-Internet related sexual behaviours, focuses on the behaviour of men. It is inevitable that in the future we will need to address the treatment of women with problematic Internet related sexual behaviours. In the author's clinic, few women have yet presented for evaluation or treatment of these problems. Our male patients confirm the existence of women engaging in these behaviours when they describe their online sexual partners and activities. Possible reasons for the failure of women to present for help at this time are beyond the scope of this article, but should be addressed in the future.

We are challenged to vigorously study the large, and growing larger, body of sexual behaviours that now includes those that occur via the World Wide Web, to define the line between sexual recreation and pathology, and to answer the question of whether we are talking about behaviours that reflect a single mechanism or multiple pathological processes. If the latter is accurate, we are bound to develop assessment techniques that assist clinicians in differentiating these processes, to develop treatment strategies that target the specific deficits, and to track both short term and long term treatment outcomes that can inform future changes in our conceptualizations and treatments. While clinicians are notoriously reluctant to standardize and manualize their treatments, this will be an inevitable demand if we are to identify what we do that works or doesn't work. With the continuing growth of the Internet, and the inevitable expansion of sexual behaviours made possible by the Internet, the mandate to do so is stronger than ever.

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