SEEKING HEALTH: THE LIVED EXPERIENCE OF BEING IN RECOVERY FROM SEX ADDICTION

by

Lawren Mundy

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SUPERVISORY COMMITTEE:

Shirley Gordon, Ph.D., RN
Dissertation Advisor

Charlotte Barry, Ph.D., RN

Josie Weiss, Ph.D., PNP-BC, FNP-BC

Douglas Broadfield, Ph.D.

Marlaine C. Smith, Ph.D., RN
Dean, Christine E. Lynn College of Nursing

Barry T. Rosson, Ph.D.
Dean, Graduate College

March 15, 2013
Date

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ABSTRACT

Author:	Lawren Mundy
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Sex addiction is the least talked about and least understood of all addictions. For individuals who self-identify as sex addicts, unique health and social consequences are not well understood because of factors, such as stigma. It is important that the nursing community understand this phenomenon to address, understand, and provide sensitive and meaningful care. However, there is limited research on this topic.

The purpose of this study was to explore the lived experience of individuals who self-identify as sex addicts. Through snowball sampling, five men and five women between 27 to 45 years old, and older. participated in the phenomenological study. Data analysis followed Giorgi's (1985) descriptive phenomenological method. Watson's (1996, 2009) *Transpersonal Human Caring* theory was the theoretical grounding for this study and guided the researcher's respectful entry into the participants' world, being mindful of the interconnection of mind, body, and spirit.

Meaning units and themes were revealed through the participants' experiences as follows: A Connecting with Others:

1. Reaching Out
2. Seeking Shared Understanding
3. Connecting with Your Higher Power

B Managing Stigma:

1. Revealing Concealing

C Integrating the Past for Recovery:

1. Reflecting Triggers
2. Overcoming Powerlessness.

D Being Vigilant:

1. Intentional Refocusing
2. Living an Honest Life

E Giving of Oneself:

1. Informing Others
2. Doing Service.

The overall structure synthesized from the meaning units and themes was:

"The lived experience of seeking health in recovery from sex addiction is dancing on the outer circle, connected to a community that understands fear, shame and the struggle to remain vigilant for pitfalls while intentionally refocusing on living an honest life of giving and receiving."

In conclusion, recovery from addiction is understood in terms of individuals "seeking help." This study reframes the experience of recovery from sex addiction as

"seeking health." Seeking health incorporates a holistic, community involved, multi-faceted approach to recovery. Understanding how individuals seek health in recovery provides a framework to impart meaningful, sensitive nursing care.

DEDICATION

This manuscript is dedicated to my family and friends who have shown understanding and compassion through this journey in my life and for sharing this success with me. Without God, this accomplishment would not have been possible, as He has brought me through this trying process, Proverbs 3: 5–6.

I also wish to dedicate this dissertation to the participants of this study, who allowed me the privilege of entering their worlds. Thank you for providing the medium for this work to emerge.

SEEKING HEALTH: THE LIVED EXPERIENCE OF BEING IN RECOVERY FROM SEX ADDICTION

LIST OF TABLES

Chapter 1: Researcher's Perspective

When an individual affected by sex addiction may seek healthcare from the emergency department, private office, or health department, his/her first healthcare interaction will be with a nurse. The emergency department nurse, office nurse, community health nurse, and advanced practice nurse have the greatest opportunity to identify these individuals, to intervene, and promote quality care. The following story, "A Significant Dream," as told by a participant, illuminates the importance of the nursing community's understanding of this population. The story describes the complexities that one faces on recovery from sex addiction, such as hiding/protecting oneself from hurt, finding self in recovery, and self-awareness. The conclusion of this story is told in Chapter 5.

> "And then I had a dream one time that there was this great big house, a beautiful mansion, and we were looking for somebody to move into that house, that big, beautiful mansion, but it wasn't really a mansion, it was just like a movie set. It fell down but there was a big house behind it. It was like a TV set that kept falling and falling and pretty soon it was a little tiny house, a little modest house. When we went in, we were so excited to find this person we'd been looking for. I and my friends were looking all over and we could see that somebody was there because the TV was still on and water was boiling in the kitchen, but she was hiding in the house. I kept thinking I know she's here, I know she's here,

and I'm looking all over the house. It was kind of like a 70s house that was clean and tidy, but it wasn't updated though. I was looking around and I remember I opened up this door and I kept dreaming of these blue butterflies. I don't know what that significance was. But I found these blue butterfly clips and I thought that they would look pretty in my hair and I put it in my pocket and I'm like, she's not here, we might as well go. As we were walking out the door, I turned around, and I looked in the window, there was a cardboard cutout of a woman with brown hair."

Introduction

Expressions of sexuality have changed dramatically over the past two to three decades in the United States (US). Conventional beliefs about sexuality have been challenged with the emergence of cybersex and activism of gay and lesbian movements. These changes have caused confusion between current norms and known boundaries of sexual behavior. The popular media have educated the general public recently on the new disorder of 'sex addiction'. From *TIME* magazine discussing the disorder through the Tiger Woods and Charlie Sheen stories (Cloud, 2011) to the VH1 show *Sex Rehab with Dr. Drew* (Pinsky, 2009), our culture has become familiar with the concept of sex addiction. Current literature suggests that sex addiction affects 17 to 37 million Americans (Hagedorn, 2009; Society for the Advancement in Sexual Health, 2007). Despite statistical significance, a formal diagnosis has not been designated for this disorder. The American Psychiatric Association (APA) is debating whether sex addiction should be added to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* under the term "hyper-sexual," which would legitimatize sex addiction in a way that was

unlikely a few years ago (Cloud, 2011). Currently, sex addiction researchers use the terms ‘hyper-sexuality’ and sex addiction synonymously; however, for the purposes of this study, the term ‘sex addiction’ will encompass ‘hyper-sexuality’. Although a formal diagnosis of sex addiction has not been designated, patients may encounter the same healthcare barriers as those affected by other addictions, such as stigma. It is vital to understand stigma as a healthcare barrier that may influence the experiences of those in the affected population who are seeking health.

Stigmatization or social disqualification of individuals affected by addiction in the healthcare arena has been profoundly studied. This injustice may occur as a consequence of the repercussions of an individual’s sexual behavior, such as unwanted pregnancies, violence, destruction of close relationships, and depression (Perera, Reece, Monahan, Billingham, & Finn, 2009; Sussman, 2007). Stigma creates a barrier to healthcare and diminishes the individual’s quality of life. Addiction-related stigma is a complex set of responses that includes some sense of personal threat, moral indignation and disapproval, anger, anxiety, and prejudice (Charney, Palacios-Boix, & Gill, 2007)**.**

As consequences of their sexual behavior, individuals affected by sex addiction develop long-lasting health problems, such as recurrent/chronic sexually transmitted infections. They typically present to their healthcare provider first before seeking care from a therapist or psychiatrist. Nurses may face complex healthcare issues while caring for these individuals. Understanding such patients’ specific experiences in seeking health is vital if the nursing community is to provide adequate, educated care.

Persons affected by sex addiction may delay approaching healthcare services because of concerns about being judged by healthcare professionals; therefore they may

receive inadequate care. As a result, such individuals may experience negative consequences through not receiving preventative care or not being treated for existing conditions. As healthcare professionals, nurses are responsible for recognizing and mitigating the deleterious effects of stigmatization and health disparities. Individuals affected by sex addiction may not know the importance of receiving healthcare, yet they repeatedly perform and seek behaviors indicative of dependence.

Care of individuals with sex addiction has been deemed challenging, and there is a dearth of nursing research into the subject. Nurses need to discover and examine the meanings and experiences of health for these individuals. Watson's (1996, 2009) *Transpersonal Human Caring* theory was utilized for this study, as it guides nursing professionals to view the individual affected by sex addiction as a spiritual, mental, and physical being so that through caring transactions, they can help the affected individual achieve harmony (Suliman, Welmann, Omer, & Thomas, 2009).

In Chapter 1, the theoretical framework and the definition of terms used in this study are introduced, the statement of the problem is set out, the significance of sex addiction, and the purpose of the study are discussed, and the research questions are revealed.

Definition of Terms

Sex Addiction: Sexual thoughts, feelings and behaviors that are experienced as distressingly out of control to the degree that negative consequences are experienced (Reid, Carpenter, & Lloyd, 2009; Winters, Christoff, & Gorzalka, 2010). Sex addiction has been theoretically associated with an addictive personality (Carnes, 1983; Goodman, 2001; Schwartz & Brasted, 1985); impulsiveness (Bancroft & Vukadinovic, 2004;

Giugliano, 2008); and compulsiveness (Coleman, Miner, Ohlerking, & Raymond, 2001; Del Giudice & Kutinsky, 2007; Leedes, 2001; Opitz, Tsytsarev, & Froh, 2009; Perera et al., 2009; Raymond, Lloyd, Miner, & Kim, 2007).

As mentioned above, there are no diagnostic criteria for sex addiction, but it has characteristics similar to those of substance dependence as defined in the *DSM*. Similarities include euphoria and unrestrained desire in the presence of the associated stimuli (voyeurism); withdrawal when separated from the behavior of choice (masturbation); focused attention on and intrusive thoughts of the sexual activity of choice; and maladaptive or problematic patterns of behavior that lead to impairment or distress despite adverse consequences (Reynaud, Karila, Blecha, & Benyamina, 2010).

Health-seeking Behaviors (HSB): This concept can be understood through the Health Belief Model (HBM) originally proposed by Hochbaum in the late 1950s (Maltby, 1999). In 1974, Rosenstock developed the model further, and four components were added as a necessity for an individual to take health action: (a) perceived susceptibility; (b) perceived seriousness; (c) perceived benefits; and (d) perceived barriers (Maltby, 1999). HSBs are actions utilized by individuals to maintain their physical, psychological, and emotional well-being. Nursing Outcomes Classification (NOC) (Moorhead, Johnson, Maas, & Swanson, 2007) defined HSB as personal actions to promote optimal wellness, recovery, and rehabilitation.

Stigma: The co-occurrences of labeling, stereotyping, separation, and social power (Link & Phelan, 2006; Reeders, 2009). According to Goffman (1963), a stigma is an attribute that discredits an individual or a group, diminishes and renders them tainted, discounted, abject, and inferior.

Theoretical Framework

Watson (1996, 2009), a prominent nurse theorist, formulated her ideas and theories from the work of other nursing theorists such as Leininger (1991). Watson and Leininger have influenced other nurse researchers to enhance the nursing profession's knowledge on care. Leininger (2002) had a global viewpoint on care, while Watson (2009) focused on its Western transpersonal aspects. Watson first published her ideas in her book *Nursing: The Philosophy and Science of Caring* (1979) and refined them in *Nursing Science and Human Care* (1985). Watson's (1985) philosophy and research were based on her perception of the metaphysical and transpersonal aspects of human beings. She emphasized that caring is a moral concept that surpasses its context and has significant implications for the nursing profession.

Watson's (2002, 2009) theory focuses mainly on the notion of transpersonal caring. This concept incorporates understanding its three components: life, illness, and health. Life is viewed through spiritual, mental, and physical components. Illness is not always a pathological condition and can be understood as disharmony with an individual's inner self or soul (Watson, 2002). Health is unity and harmony within the individual's spirit, mind, and body (Watson, 2002).

Watson (1996) asserted the importance of nurses and individuals developing transpersonal relationships experienced during caring interaction. If the interaction is transpersonal then a connection develops between the nurse and the individual. Transpersonal human caring involves the nurse touching another's spirit with the goal of bringing balance between body, soul, and spirit to that person. Watson's (1996) transpersonal process did not focus on the 'what,' but the 'how,' and entailed five steps.

First, the nurse enters the individual's experience; second, the nurse perceives the individual's condition of being; third, the nurse internalizes the person's condition; fourth, the nurse responds to the person's condition in which openness occurs and the individual expresses their feelings; and the last step occurs as the individual releases negative feelings and thoughts and moves from illness to health with nursing support. Watson further delineated 10 caritas processes that were applied to the individuals affected by sex addiction during the study:

1. Formation of a humanistic-altruistic system of values
2. Instillation of faith and hope
3. Cultivation of sensitivity to oneself and others
4. Development of a helping-trusting, human caring relationship
5. Promotion and acceptance of the expression of positive and negative feelings
6. Systematic use of a creative problem-solving caring process
7. Promotion of transpersonal teaching-learning
8. Provision for a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. Assistance of gratification of human needs
10. Allowance for existential-phenomenological spiritual forces (Bailey, 2009; Wade & Kasper, 2006; Watson, 1996).

Watson's (1996) model of caring "calls for a return to reverence and a sense of sacredness with regard to life and human experiences, especially those related to caring and healing work with others during their most vulnerable moments of life's journey" (p. 145). For this study, Watson's (1996, 2009) *Transpersonal Theory* guided the researcher

into the world of the individual affected by sex addiction. The theory is based on values that honor another's autonomy, freedom of choice, and becoming. Human caring is relational, transpersonal and intersubjective, and is the core of all human relationships (Wade & Kasper, 2006). Nurses are seen as agents of transpersonal caring who enter the lives of persons affected by sex addiction. When the transpersonal theory is incorporated, caring underlies all interactions between the nurse and the affected population.

Nurses need to be aware of their own feelings when caring for individuals suffering from addiction and of how profoundly, although unintentionally, their actions affect the life of the individual. Watson (2002, 2009) believes nursing should be concerned with the pursuits of hidden truths and new insights, developments of new knowledge in relation to human behavior in health and illness, and making new discoveries of how to be in a professional human caring relationship with individuals to serve society. A vital call for the profession is to strive for respect, reciprocity and mutuality in providing care for all individuals**.** Nurses understanding the HSBs of individuals affected by sex addiction could lead to discoveries of how nurses develop a professional human caring relationship with such people.

Watson and Stigma

Watson's (1996) caritas processes guide the nurse to practice his or her profession with a keen awareness and guided by scientific knowledge, methods, and predictions. Nurses may implement Watson's (1996) processes, such as the cultivation of sensitivity to oneself and others; development of a helping, trusting environment; and promotion and acceptance of the expression of positive and negative feelings in the plan of care to foster a non-judgmental environment. Concurrently, nurses are to examine and understand the

meaning of human actions and values that guide illness and health (Watson, 2002, 2009). As healthcare professionals, nurses are responsible for recognizing and mitigating the deleterious effects of stigmatization and health disparities. Persons affected by addiction delay approaching healthcare services because of concerns about being judged by healthcare professionals and receiving inadequate care. As a result, these individuals suffer negative consequences, including limited access to healthcare and prejudice.

As stigma has been identified as a major barrier to healthcare and quality of life (Deacon, 2006), it is important for nurses to address their own feelings, attitudes, and moral beliefs regarding individuals involved in addiction. Watson (2002, 2009) asserts that nurses need to acknowledge and respect the spiritual dimension of life and the power of the human care process. This process relies on the affected individual's ability to grow and change. Stigma can be minimized if nurses believe that individuals affected by addiction can change and develop positive behavior patterns. If caring is to be effective and sustained, nurses must have inner strength and be capable of peace, love, and happiness within themselves and others (Watson, 2002).

Statement of the Problem

Sex addiction appears in the literature under a number of names, such as hyper-sexuality, compulsive sexual disorder, and others discussed in the definition of terms. Regardless of the name attached to the behavior, the patients' problems create a number of health consequences that bring the affected population to the healthcare system. Since healthcare professionals are unaware of how individuals affected by sex addiction may present to the healthcare system, they may assess and treat them incorrectly. The nursing community needs to be aware of the affected population and of what services may be

used to obtain healthcare. Sexual behaviors of the affected population may include unsafe sex, exhibitionism, prostitution, compulsive masturbation, and pedophilia (Roller, 2007). These individuals may present to health clinics or emergency departments if they are experiencing physical symptoms, such as abnormal genital discharge, injured genitalia, genital bleeding, or genital itching. Entering a healthcare agency with symptoms constitutes a health-seeking behavior.

Persons affected by sex addiction may also present to the health department for psychosocial difficulties, such as depression. If anonymous sex is the behavior of choice for these individuals, they may schedule appointments for routine sexually transmitted infection screenings at the local health departments, private office, or medical clinics every 3 to 6 months. Common reasons for seeking healthcare include sexually transmitted infection testing, necessary vaccination, or gynecological, digestive, and psychosocial issues (Ngyuen, Venne, Rodrigues, & Jacques, 2008). The affected population may seek psychosocial therapy from clinics, therapists, or 12-step programs, such as Sex Addicts Anonymous. Each of these individuals has unique personal characteristics and experiences, such as complex lifestyles, a history of childhood sexual abuse, a history of trauma/neglect, or multiple sexual partners, all of which affect subsequent actions, including their healthcare (Current Nursing, 2009).

As the population of interest presents to its chosen facilities for healthcare, it is vital that nurses know how to promote and improve the health of these individuals properly. Inadequate training of nurses may lead to the labeling of “difficult” patients in addition to other negative attitudes in caring for these individuals (Lindberg, Vergara, Wild-Wesley, & Gruman, 2006).

Marginalized populations—women and men affected by addiction—experience barriers to healthcare due to diseases or conditions. They become more vulnerable when other problems, such as poverty, age, or sexual orientation, also identify them. This double stigmatization can lead to poor healthcare (Edwards & Timmons, 2005; Weiss, Ramakrishna, & Somma, 2006); misdiagnosis (Edwards & Timmons, 2005); low self-esteem (Hebel & Dovidio, 2005); and depressive symptoms (Edwards & Timmons, 2005).

The stigmatic responses to addiction have been recognized as a hindrance to the health of individuals suffering with addiction (Kaplan & Krueger, 2010). Negative health outcomes may result from the interaction between the nurse and person affected by addiction. Public health implications include stress and its health consequences, termination of treatment, and delaying appropriate healthcare. Improvement of healthcare entails providing information and opportunities, offering a supportive environment, services, and facilities for making positive choices. The care should be appropriate to the individual's economic, cultural, social, and physical needs and provide a holistic healthcare environment. Nurses are important sources of interpersonal influence that can increase or decrease commitment to and engagement in health-promoting behavior (Current Nursing, 2009). Understanding the experiences of individuals seeking health who self-identify as sex addicts will allow the nursing community to provide optimal care.

Purpose of the Study

By utilizing Giorgi's (1970, 1985) phenomenological method, the purpose of this study was to evaluate the experience of seeking healthcare for individuals who self-identified as sex addicts. The results may help nurses to better understand the lived experience of the affected population and therefore provide appropriate and adequate healthcare. By increasing awareness of this phenomenon, the researcher desired to educate nurses in emergency departments, private office settings, and health departments who may encounter individuals affected by sex addiction.

Research Question:

What are the experiences of individuals who self-identify as sex addicts and who seek healthcare?

To answer this question, the researcher conducted a single, semi-structured, audio-taped interview using open-ended questions with participants who self-identified as sex addicts.

Significance of Sex Addiction

Nationwide statistics on sex addiction. In our society, sex addiction is among the least talked about and understood of all the addictions. Lack of knowledge and understanding of this topic may be attributed to our culture's reluctance to discuss sexuality candidly. Although this resistance exists, it is important for nurses to recognize the significance of sex addiction to address, value, understand, and care fully for the affected population. It is estimated that 3–5% of the U.S. population is affected by sexual addiction, with 85% of sex addicts being male and 15% female (R. Weiss, personal communication, July 15, 2011). Considered conservative estimates, these figures only

reflect individuals who seek treatment and do not encompass all persons suffering from sex addiction.

As the foundation of sex addiction is rooted in childhood or adolescence, it is important to note that 60% of individuals with sex addiction were abused by someone during their childhood (Charney et al., 2007). Sexual abuse sometimes occurs alongside additional risk factors that are indicative of family dysfunction, such as substance abuse, psychiatric illness, and impaired parent-child relationships. As a result of the abuse and dysfunction the affected person develops an addiction to sex as a coping mechanism. Consequences for these individuals include acquiring sexually transmitted infections, bodily injury, unplanned pregnancies, depression, loss of relationships, stigmatization, and loss of jobs (Opitz et al., 2009). Research discussed in Opitz et al. (2009) found that 25–50% of women who engaged in sexually addictive behavior have had at least one abortion.

Cost of sex addiction. Sexual addiction has become a costly problem to American society, a fact publicized through media sources, such as Oprah Winfrey's TV show and nightly news reporting of the millions of dollars lost by the Catholic Church in litigation and compensation payments. In addition to these sums, the estimated costs of the resulting loss of productivity, absenteeism, and replacement in the workplace are astounding (Salladay & Kent-Ferraro, 2002). In addition, lost family revenue and diminished economic infrastructure (taxes and unemployment) also add to the cost of sexual addiction.

The cost to society also includes the financial impact of the therapeutic business sector, seen primarily through community events. For example, New Life Ministries in

California hosted the 3-day seminar “Every Man’s Battle,” addressing the battle against shame, fear, and pornography (Ley, 2011). The cost of this seminar to attendees was $1,400, not including room and board. The seminar’s website also offered kits, self-study resources, and books aimed at men, women, families, and adolescents. In 2009, New Life Ministries made approximately $4 million from educational materials and $2.5 million from seminars (Ley, 2011). On tax return documents in 2009 the organization reported a gross income of $8.5 million. Stephen Arterburn, the leader of this organization, was paid $180,000 in 2009, not including speaking fees (Ley, 2011).

Cost of treatment is a pertinent factor of sex addiction that lacks research; however, the prevalence and treatment needs of individuals affected by sex addiction demonstrate that considerably more research is warranted. According to research discussed in Opitz et al. (2009), 32.2% of females and 17.4% of males indicated a need for further evaluation and treatment of sex addiction. While there is a dearth of literature on the cost to society of the treatment of sex addiction, its cost to the individual can be estimated. The 6-day outpatient treatment program at Institute of Sexual Health in Beverly Hills, California, costs $3,000 (R. Walston, personal communication, May 21, 2010). The Sexual Recovery Institute in Los Angeles, California has an intensive 2-week outpatient program at the cost of $7,500 and an additional outpatient program for $500 per session, which offers a sliding scale based on income (B. Owen, personal communication, May 21, 2010). Sante Center for Healing, located in Argyle, Texas, offers in-patient treatment at the cost of $790 per day, with a recommended stay of 45 to 60 days, and an outpatient program for $200 per session (S. Emmert, personal communication, May 21, 2010). Information on rehabilitation facilities and the cost of

treatment is a vital resource for nurses caring for the individual affected by sex addiction so that optimal care can be provided.

An August 2007 survey revealed that 92% of nurses wanted more information to cope with an increasing workload related to addictions (Harrison, 2007). Inadequate education of nurses may lead to the labeling of “difficult” patients in addition to other negative attitudes in caring for persons affected by addiction (Lindgerg et al., 2006).

Chapter Summary

In Chapter 1, the concepts of stigma, sex addiction, and HSBs were defined. The purpose of the study, statement of the problem, significance of sex addiction, and theoretical framework were discussed. Finally the research question was introduced.

Chapter 2:

Review of the Literature

Chapter 2 provides a review of the classic and current literature on the topics of sex addiction, stigma, and health-seeking behaviors. The first section provides an in-depth definition of sex addiction, along with a discussion of the concept's historical perspective. This is followed by a description of the concepts of stigma and health-seeking behaviors. Finally, a review of current quantitative and qualitative studies are discussed and evaluated. The discipline of psychology provides the majority of the current literature review, while the discipline of nursing contributes a portion. As nurses are among the first healthcare providers to encounter individuals affected by sex addiction, there is a need for sex addiction research in the discipline. The literature review supports the need for qualitative nursing research on how stigma affects the health-seeking behaviors of individuals affected by sex addiction.

Sex Addiction

Definition of sex addiction. Since the publication of the American Psychiatric Association's *DSM–III-R* (APA, 1987) was published, several sex researchers and authors have found that some forms of sexual behavior portray the classic attributes of addiction: tolerance, withdrawal symptoms, obsession, compulsion, lack of control, and continuance of the behavior despite negative consequences (Carnes, 1991; Goodman, 2001; Greiner &, 2008; Kranzler & Li, 2008; Kwee, 2007; O'Keefe et al., 2007; Sussman, 2007). Classic authors, such as Carnes (1991) and Goodman (2001) have

suggested and proposed criteria for sexual addiction to be included in the *DSM*. Criticism of the construct of sex addiction as a definition, an addiction, and a diagnosis stems from authors' beliefs that sexual behavior is an impulse disorder (Giugliamo, 2008; Bancroft & Vukadinovic, 2004), while others believe that it is an obsessive-compulsive disorder (Coleman et al., 2001; Del Giudice & Kutinsky, 2007; Leedes, 2001; Opitz et al., 2009; Perera et al., 2009; Raymond, et al., 2007).

Initially, one may think there is no consensus on the definition of sex addiction among authors, but the classic writers suggest otherwise. Goodman (1998) defines sex addiction as a condition in which some form of sexual behavior is engaged to relieve painful affect and/or for pleasure seeking. The affected individual continues the behavior regardless of potential negative consequences. Carnes (1989) defines it as a pathological relationship with a mood-altering experience that allows the sex addict to be identified by the hallmarks of lack of ability to control their sexual feelings, thoughts, and behaviors. Balswick and Balswick (1999) agree with Goodman's definition, but also utilize a portion of Carnes's (1983) definition of the condition as a pathological relationship with a mood-altering experience.

Wines (1997) concurs with Carnes (1983) and argues that addictive sexual behavior is distinguished by the capacity both to produce pleasurable affects and to provide a means for the evasion of painful internal states. Earle, Crow, and Osborn (1998) agree with Carnes' (1983) definition and etiology of sex addiction. Sussman (2007) utilizes Carnes (1983), Wines (1997) and Goodman's (1998) ideology and defines sex addiction as "a pattern of sexual behavior that is initially pleasurable but becomes unfulfilling, self-destructive, and that a person is unable to stop" (p. 258). It is evident

that researchers give great attention to the seminal work of Carnes (1983), as his construct and model of defining and treating sex addiction has been reviewed and applied to research globally.

History of Sex Addiction

Descriptions of addiction or out-of-control sexual behavior can be traced back to the Greek myths, with their depictions of satyrs and stories of the god Dionysius. Actually the Greeks created the term 'nymphomania', which was used to describe female sexual excess (Finlayson, Sealy, & Martin, 2006). In the 19th century, the term 'Don Juanism' was coined to describe male sexual excess. Krafft-Ebbing (1965) presented one of the first case studies detailing how out-of-control sexual behaviors affected the male client. Despite sparse historical descriptions of excessive sexual behavior, the notion that it can be conceptualized as an addiction or compulsion warranting psychiatric treatment is relatively recent. In the mid to late 20th century, several case studies were published describing clinical presentations of individuals reporting out-of-control/compulsive behaviors, even though the definitions and etiology varied greatly from today (Aureback, 1968). Examples of terms used included nymphomania, Don Juanism, perversions, paraphilia, compulsive sexual behavior, and impulse control disorder.

Although out-of-control sexual behavior can be dated back to the Greeks, the concept of sex addiction did not emerge until the late 20th century (1970–1999). The particular ambivalences of that particular period shaped previous conceptions of the sex addict, such as the hypersexual female and the phobic female. The medicalization of socio-sexual issues, such as sex addiction has a century-long history. The 19th century marked a shift in scientific involvement in sexuality, allowing the medical community to

expand its involvement in, and control of, sexual matters. During the latter part of the 20th century new sexual diseases and identities were noted that regulated sexuality. Sex addiction, with its discourse of excess and control, is one of the most recent medical constructions to signify extreme disorder (Irvine, 1995). The idea of compulsive and dangerous sexuality emerged in the 1970s as a serious medical condition.

History of the Definition

Health professionals did not recognize sex addiction as a medical condition until the individuals affected by it claimed their own disease status. Once the medical community had taken cognizance of the new disease state, its contribution helped to popularize and legitimize the concept. The concept of sex addiction was legitimatized further by its inclusion in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM),* a handbook for healthcare professionals to use in diagnosing patients. The concept has expanded vastly from drugs and alcohol to include sex, smoking, gambling, and food. The relinquishment of control by the addict is the main characteristic that professionals use to define addiction. Biology, psychology, sociology, nursing, and biochemistry are disciplines concerned with addiction and its potential consequences.

In 1980, the authors of the *DSM* third edition emphasized that withdrawal and tolerance were necessary for an accurate diagnosis of dependence (APA, 1980). In 2000, the APA identified seven criteria that apply to a diagnosis of addiction or substance dependence, though only three of these need be met for a diagnosis: tolerance; withdrawal symptoms; the substance is taken in larger amounts for longer periods than intended; efforts to stop or reduce use have repeatedly failed; more time is spent in

activities associated with use of this substance; important activities are given up or reduced; and use is continued despite knowledge of its detrimental effects (APA, 2000). Experts in psychology and psychiatry have viewed individuals with addiction as being dependent on their chosen agent that renders them powerless to stop addictive behavior. Dependency on the agent of choice signifies lack of control over behavior and decision-making (Kranzler & Li, 2008; Olmstead, 2006).

Kranzler and Li (2008) discussed the most recent text revision of the manual, *DSM* IV-Text Revision (*DSM-IV-TR*) (APA, 2000), in which addiction was recognized as impaired control over substance use. Professionals working with patients experiencing non-drug related compulsions have questioned why these compulsions cannot be recognized as addictions (Keane, 2004). Individuals affected by sex addiction are dependent on their choice of behavior, which renders them powerless to stop. Dependency on the agent of choice signifies lack of control over behavior and decision-making (Olmstead, 2006). Although this controversy continues, the term 'addiction' encompasses not only substance use but also all compulsive behaviors. The affected individual lacks control over a self-destructive behavior, participates for longer periods than intended, spends increasingly greater amounts of time engaged in the behavior, has tried to stop and failed, gives up or reduces important activities to accommodate the behavior, and engages in the behavior despite knowledge of its detrimental effects.

History of the Concept

Professional interest in sex addiction became widespread in the early 1980s. In 1983 Carnes introduced the concept of sex addiction formally. His definition corresponds to that of substance abuse in that it is an ongoing pattern of uncontrolled behavior. Carnes

believes that the addict uses sex as a tool to relieve pain and stress, but that the core of the addiction is fear of being abandoned and shame. “He (Carnes) emphasized that this form of sexual behavior is maladaptive because it persists despite the risk of substantial potential adverse consequences” (Gold & Heffner, 1998, p. 375). Carnes (1983) believes that sex addicts will sacrifice their jobs, relationships, and possibly contract a life-threatening illness as a consequence to their sexual behavior. He posits a sex addiction model with six phases. The first is called the initial phase, in which some event interacts with the individual to cause the addiction. The second is the establishment phase, where behavioral patterns are set and the addictive cycle begins to repeat itself. The third is the contingent phase, which is intertwined with a fourth phase called the escalation mode, where the cycle of addiction is completely established (Carnes, 1983).

The escalation mode is followed by de-escalation mode, where the behavior may decrease but the addiction is firmly established. This fifth phase is acute and is noted by a break in reality and fiction. In this phase, the addict will continue with the behavior regardless of negative consequences, such as repeated abortions. The sixth is known as the chronic phase, where the behavior is irreversible, the client no longer responds to treatment, and they are usually institutionalized (Carnes, 1983). In 1985, Carnes founded the first in-patient program for sex addicts at the Golden Valley Health Center’s Sexual Dependency Unit in Minneapolis.

In his first published book *Out of the Shadows*, Carnes discussed how early victimization experiences led to sex addiction (Carnes, 1983). This book also discussed sex addicts in the making and at an early age, they learn to thwart painful feelings of loneliness through sexual fantasies and self-destructive sexual behaviors. Although the

etiology of sex addiction was not yet known, three common hypotheses have been reviewed.

Etiologies of Sex Addiction

The primary etiology discussed in sex addiction research is trauma history. Giugliano (2006), explains "how dissociative defenses are used to protect an individual from feelings of helplessness, lack of control, and/or realities of the traumatic events" (p. 362). There is a general assumption in the sex addiction field that childhood sexual abuse can cause sexual difficulties in adulthood, including sex addiction. Schwartz and Southern (2000) showed that 76.2% of the female participants in the clinical population indicated a history of sexual abuse. This is in agreement with Carnes (1991), who noted that 39% of men and 63% of women affected by sex addiction reported sexual abuse. Dahlen, Colpitts, and Green (2008) studied 298 addicts, 81% of whom reported sexual abuse and 97% of whom had experienced emotional abuse from within their family. The victims of sexual abuse had higher rates of psychiatric co-morbidities, such as depression, anxiety, and substance abuse. Opitz et al. (2009) also noted a positive correlation between sexual addiction, sexual abuse, depression, and substance abuse.

Neurobiology is another proposed etiology of sex addiction and can be viewed as an extension of trauma theory. Researchers have noted that experiences such as post-traumatic stress disorder (PTSD) can cause neurobiological changes (Carter & Dalla, 2006; Giugliano, 2006; Howard, 2007; Opitz et al., 2009). Trauma specialists contribute PTSD to the genesis of addictive disorders. Giugliano (2006) discussed neurobiological changes of reduced synaptic numbers and amount of serotonergic projections in the hippocampus, which may result in dissociative and amnesic signs and symptoms of

PTSD. Soldiers returning from combat are known to be at high risk of using addictive sexual behavior to escape memories of combat (Howard, 2007).

As important as the genitalia are to sex addiction, so is the neurobiology of the brain. “The amygdala, which is the center for sexual arousal and desire, is also part of the limbic system in the brain which is stimulated by drugs such as cocaine” (Roller, 2007, p. 488). Sexual response assists in the production of neurochemicals, such as catecholamines. Sexual pleasure stimulates euphoric neurotransmitters, which, in turn, activate pleasure regions in the limbic system. When the individual’s pleasure region is stimulated and euphoria is attained, the behavior is repeated continuously to accomplish a “high.” Persons affected by sex addiction develop a tolerance to the neurochemicals and need increasing amounts to feel normal (Goodman, 2005; Roller, 2007).

Mood state is another proposed etiology of sex addiction. In the 1990s, when the construct of sex addiction emerged in the United States, researchers considered anxiety as a causative factor. Unpleasant levels of anxiety were thought to be decreased by some sort of sexual behavior (Giugliano, 2006; Moskowitz & Roloff, 2007). Gold and Heffner (1998) noted that sexual acts previously performed by an individual with sex addiction no longer relieved the anxiety, so additional and more intense acts were sought to achieve the desired effect.

Studies supplementing the work of Gold and Heffner (1998) have added depression to the explanation of mood state as a possible etiology of sex addition. Individuals with depression attempt to enhance their mood through sexual behavior. Sex is used to raise self-esteem (Charney et al., 2007; Moskowitz & Roloff, 2007; Perera et al., 2009), to obtain personal contact (Giugliano, 2006; Zapf, Greiner, & Carroll, 2008),

and to feel validated (Moskowitz & Roloff, 2007). Individuals with depression tend to engage in risky sexual behaviors and are not concerned with the possible consequences. Because of the complexity of the lifestyles led by individuals affected by sex addiction, along with the unrecognized diagnostic criteria, nurses may find it challenging to identify and care for the affected population.

Stigma

American sociologist Erving Goffman first introduced the idea that the experiences and/or characteristics of an individual may have stigmatizing consequences in 1963. He explains the notion of stigma through in his book *Stigma: Notes of the Management of Spoiled Identity* (1963), which focuses on individuals who are not "normal" and who are marginalized in some way. Goffman (1963) explains how individuals are pressured by society to present as "normal" or, as Goffman would call it, to "pass" (p. 58). Goffman went beyond the common experiences to those lived by certain individuals who must plan their daily activities to manage the effects of stigma.

According to Goffman (1963), society establishes standards for what is considered normal, ordinary, and natural. We do not become aware of the normative standards until we are presented with a person's undesirable attribute, in which the individual is "reduced in our minds from a whole and usual person to a tainted, discounted one" (p. 12). Stigma is a discrediting attribute and as noted by Goffman (1963), is the discrepancy between a person's virtual and actual social identity. Since the publication of Goffman's (1963) book, several variations of the definition of stigma have been noted in the literature.

Jones, Farina, and Markus (1984) viewed stigma as a relationship between an attribute and stereotype, a mark (attribute) that links an undesirable characteristic to the individual (stereotype**).** Crocker **(**1999) believes that stigmatized individuals have some characteristic that conveys an identity that is devalued in society. Although different phrases of the definition have been developed, most conceptualizations agree that stigma: (a) consists of an attribute that marks one as different and results in devaluation, and (b) is dependent on relationship and context, which is socially constructed (Crocker, 1999).

Several writings on the topic of stigma have been developed since Goffman's (1963) work, and the concept has been applied to several situations ranging from mental illness (Perese & Perese, 2003), human immunodeficiency virus (HIV) (Abel, 2007), and obesity (Merrill & Grassley, 2008). Some researchers have criticized the common definitions of stigma and tend to define stigma as "something in the stigmatized person, rather than as a designation that others attach to the individual." Researchers have focused mainly on the affected person rather than on society's influence on exclusion from social life (Parker & Aggelton, 2003).

In response to this argument, Link and Phelan (2006) developed the sociological conceptualization of stigma that defines it as five interrelated concepts. First, people label and distinguish human differences; second, dominant cultural beliefs link the labeled person to characteristics; third, the labeled person is put into categories of "us" and "them"; fourth, emotional reactions occur in the stigmatized (shame) and in the stigmatizer (anger); and fifth, the labeled person experiences status loss and discrimination. Under Link and Phelan's (2006) conceptualization of stigma each factor may vary based on the context, but is dependent on power (social, economic, political)

and does not exist without it. Deacon (2006) argues that power hierarchies do not have to be present for stigma to exist and even in the absence of active discrimination; stigma may still have a negative impact on the labeled person.

A stigma can be attached to a visible characteristic of an individual such as a deformity, skin color, or personal appearance (Goffman, 1963). These attributes are obvious to others and may stimulate negative treatment of the stigmatized persons in the community, personal relationships, and by classmates, and workers (Major & Eccleston, 2004). A person who has a visible attribute that is stigmatized by society cannot control whether or not other individuals choose to stereotype them. In contrast, an individual with an invisible characteristic (sex addiction, HIV, mental illness) can control who knows about their stigmatized characteristic by deciding whether or not to disclose it to others.

When individuals with invisible stigmas decide not to disclose, they can minimize the impact on their relationships, but this can lead to other problems, such as self-stigmatization. In this is the process, the labeled person internalizes their illness stigma and experiences diminished self-esteem and self-efficacy (Karidi et al., 2009). Stigma can have a significant impact on the individual's view of self when the negative attitudes of society are incorporated into one's sense of self. This phenomenon can be seen among individuals with sex addiction as they begin to accept negative societal attitudes. When internalization of these attitudes occurs, these individuals experience lack of self-confidence, withdrawal from society, resulting in low self-esteem, negative impacts on health outcomes, and an increase in anxiety/depression (Alschuler, 1986; Link & Phelan, 2006; Rozas, 2007). Despite the type of stigma (invisible/visible; health/social) and the

level of stigma attached to the issue, possessing a stigmatized attribute can influence an individual's decision to disclose, relationships with family/friends, discrimination in healthcare, and overall well-being (Major & Eccleston, 2004; Link & Phelan, 2006).

Impact of Stigma

Healthcare encounter. Some social situations are more threatening to social identity than others are. The healthcare interaction is one in which the potential for threats to an individual's identity is raised for several reasons. First, stigmatized social identities associated with behaviors such as sex addiction that are concealed in public domain are exposed during the history-taking process and/or examination. Second, the healthcare encounter is where the person affected with sex addiction may be silent due to power differences between provider and patient; healthcare providers have been known to have negative expectations and biases towards stigmatized groups (Bernstein & Kane, 1981; Green et al., 2007; Sabin, Rivara, & Greenwald, 2008). Several authors have documented that patients with stigmatized identities believe healthcare providers see them as less worthy of adequate care and not intelligent due to their identity (Becker, Gates, & Newsome, 2004; Gaston-Johansson, Hill-Briggs, Oguntomilade, Bradley, & Mason, 2007; Puhl, Moss-Racusin, & Schwartz, 2007). Patients with a new or existing stigmatizing disease such as, Chlamydia may be vigilant for signs of disapproval from their healthcare provider (Golden, Conroy, O'Dwyer, Golden, & Hardouin, 2006).

The threat of stigma for an individual affected by addiction during the medical encounter can have several negative consequences that undermine health promotion and caregiving. This threat may cause physical and psychological stress (Ben-Zeev, Fein, & Inzlicht, 2005) that influences health outcomes, such as cardiovascular disease, immune

disorders, depression, and anxiety (Brondolo, Rieppi, Kelly, & Gerin, 2003; Edwards & Timmons, 2005). Stress may also lead to unhealthy coping mechanisms such as smoking, binge drinking/eating, drug use, and avoidance of healthcare.

Community. Media representation of addiction is extremely powerful and can supersede people's own personal experiences in how they view addiction. Unfortunately, media representations are inaccurate and shaped by stigmatizing attitudes. These inaccuracies influence public opinion regarding how a person with an illness should be treated and managed (Webster, 2005).

Although the media may supply misguided information on sex addiction, in the past year the popular media has been a primary source for educating the public on the new topic of sex addiction. From *TIME* magazine's **(**2011, February 28, pp. 44–50**)** discussion of the disorder through the Tiger Woods and Charlie Sheen stories (Cloud, 2011) to the VH1 show *Sex Rehab with Dr. Drew* (Pinsky, 2009), our culture has become familiar with sex addiction**.**

The family members of an individual affected by sex addiction are usually the person's only support system. Stigmatization of being the support person or caregiver to the individual may lead to stress and anxiety (Mitchell & Knowlton, 2009)**.** Besides stress and anxiety, the treatment needs (counseling) of the affected individual may deplete financial resources and the family's social networks may be reduced, leading to loneliness and isolation (Beeson, 2003).

Providing support for an individual with sex addiction may be burdensome and result in high levels of social isolation, and symptoms of depression and anxiety (Lawrence, Fauerbach, Heinberg, Doctor, & Thombs, 2006). Avoiding stigmatizing

social situations and social withdrawal from the support system may be an attempt to protect the loved one affected by sex addiction and themselves from experiencing stigmatizing situations. Social withdrawal may lead to less social support and subsequently increase strain on the individual (Mitchell & Knowlton, 2009). Gordon's *Theory of Shared Vulnerability* (2007) describes the challenging process caregivers experience in managing care of a stigmatized group. Although Gordon's theory focuses on children with persistent head lice, the concept is easily applicable to individuals affected with sex addiction. Nurses are to consider using theories, such as *Theory of Shared Vulnerability* (2007), while developing a plan of care for the affected and their family.

Health-Seeking Behaviors

HSBs are actions utilized by individuals to maintain their physical, psychological, and emotional well-being. Nursing outcomes classification (NOC) (Moorhead et al., 2007) defined HSBs as personal actions to promote optimal wellness, recovery, and rehabilitation. Seeking health encompasses HSBs. According to Asch et al. (2006), women in the United States frequently do not receive the recommended healthcare despite the advanced healthcare system. Of women 40 and older, 60% had a mammogram in the past 2 years, and 75% of women 18 and older completed a pap smear within the past 3 years (Centers for Disease Control and Prevention [CDC], 2010). Women do not seek care for a variety of reasons such as lack of access, fear of diagnosis, and lack of insurance. According to the CDC (2010), in the United States 16% of women under the age of 65 are without health insurance coverage.

Men have a higher mortality rate for many of the leading causes of death including heart disease, cancer, diabetes, and suicide (National Center for Health Statistics [NCHS], 2006). Despite this, men are less likely to go to the doctor for physical and mental health problems or to have a primary care provider (Jarrett, Bellamy, & Adeyemi, 2007). According to the CDC (2010), in the United States 19% of men under the age of 65 are without health insurance coverage. In the United States 37% of men 18 years and older participate in physical exercise; 23% of men 18 and older smoke; 33% of men 20 and older are obese; and 31% of men 20 and older have hypertension (CDC, 2010).

As minimal research has been completed on how stigma affects the HSBs of individuals dealing with sex addiction, similar marginalized populations that have been impacted are reviewed. Pregnant women positive with HIV are one population facing stigmatization in the healthcare sector. Lancioni, Harwell and Rustein (1999) found that HIV- positive women were disinclined to receive prenatal care for reasons that included fear of disclosure and anger from healthcare professionals. These women believed that the providers have negative attitudes towards them because of the lack of understanding shown towards their reproductive choices and because of the view that “infected women” should not reproduce (Rochon, 2008). Ahmed, Stewart, Teng, Wahoush, and Gagnon (2008) argued that when HIV-positive, the women feel that the provider is too rushed and avoided questions regarding healthcare. In return, these women make their own healthcare and childbearing decisions without consulting a professional, contributing to the increase in HIV morbidity and mortality of women and children (Rochon, 2008).

African American men with mental health disorders are another stigmatized group that encounters negative healthcare experiences. When mental disorders such as depression are not treated, African American men are vulnerable to suicide, homelessness, substance abuse, incarceration, and homicide (Calloway, 2006). These men have higher rates of suicide: 72% by firearms and 20% by strangulation among males 15–19 years of age (Calloway, 2006). Social stigma, inequality in healthcare, and disclosure about mental health disorders are issues that impact the mental health of this population and therefore may prevent positive healthcare encounters. In Calloway's (2006) study, the men verbalized experiences of being stigmatized in the healthcare setting such as being addressed in a subordinate manner or having the examination room door left ajar while they were "half robed."

As individuals with mental health disorders or pregnant with HIV encounter stigmatization in the healthcare sector, so do individuals affected by sex addiction. They may or may not seek care for preventive health, but will present to the healthcare system for treatment as a result of the consequences of their sexual behavior. According to Roller (2004), 45% of women with sex addiction have contracted sexually transmitted infections, 70% routinely risk unwanted pregnancies, 40% have unwanted pregnancies, 36% have abortions, 60% are victims of physical abuse, and 21% are involved in accidents during their sexual behavior. In the study by Zapf et al. (2008), 44 % of men affected by sex addiction were characterized by high scores of anxiety and avoidance. To make the healthcare system more accessible and responsive to individuals affected by sex addiction, it is imperative for nurses to understand their HSBs and the factors determining utilization of care.

Review of Research on Sex Addiction

Sex addiction in nursing literature. A dearth of literature on sex addiction from the perspective of nursing translates into a limited focus on and knowledge of sex addiction as a significant, challenging healthcare issue. For example, Fontaine's (1995) psychiatric mental health nursing textbook contains one chapter on the focus of sex by the individual with sex addiction. Sex addiction is described as a progressive self-mediating disorder with a payoff of short-lived release from pain and an end result of unmanageable consequences.

Haber (2001) identified the problems that may occur within families and communities because of individuals with sex addiction. Sexual behaviors such as compulsive masturbation, exhibitionism, sexual abuse, voyeurism, and extensive use of pornography, are public and private clues to sexual addiction. Haber (2001) focused on the impact these behaviors can have on communities and families, and on how the behaviors influence the involvement of social, legal, and economic systems. Roller (2007) discussed sex addiction in women as a growing trend in the US. According to Roller (2007), women with an addictive behavior use sex as an anxiety-reducing agent, not as a response to desire. Health consequences for these women include abortions, violence, and unwanted pregnancies. Roller (2007) sought to increase nurses' awareness of women with addiction and to improve providers' understanding of addiction, assessment, diagnosis, and intervention options. There is a paucity of literature on the link between stigma and sex addiction; therefore, it was difficult to obtain research studies on the topics conjointly. Since the majority of sex addiction research has been completed in psychology, quantitative and qualitative studies are reviewed in this area.

Quantitative research. Eisenman, Dantzker, and Ellis (2004) undertook a study concerned with the degree to which the addiction to drugs, sex, love, and food correlate. A random survey was conducted of 9,313 college students (3,083 males and 6,230 females) on the degree of dependency/addiction to alcohol, amphetamines, barbiturates, love, chocolate, cocaine, coffee, cigarettes, gambling, sex, heroin, food, and marijuana. The results were scored on a scale from 0 to 100. Zero indicated 'not at all' and 100 indicated 'extreme dependency/addiction'. Findings indicated that males reported dependency/addiction in the areas of alcohol, amphetamines, barbiturates, cocaine, gambling, and marijuana; and females reported dependency on chocolate, food, and cigarettes. Heroin use ratings were 0.40 for females and 0.74 for males, while love rated 49.67 for females and 49.13 for males. Addiction to love correlated with addiction to sex by 0.48. A high correlation for both sexes was also noted between sex and love dependency. Asking the participants one question that was applicable to 14 categories was seen as a limitation of this study.

Morrill, Kasten, Urato, and Larson (2001) completed a 6-month quantitative study to develop and test a model for predicting the sexual risk for sexually transmitted infections. The authors recruited 528 men and women with a history of substance abuse living in a recovery facility. During the 90-minute structured in-person interview, the participants were asked about their drug and alcohol use, sexual conduct, and history of psychiatric illness. In addition to the interview, Morrill et al. (2001) used several instruments. The Risk Assessment Battery (RAB) questionnaire was used to assess the participants' sexual risk in the previous 6 months. Examples of questions on the RAB included frequency of trading sex for money or drugs and how often condoms were used

for intercourse. An Addiction Severity Index asked about the participants' histories of physical or sexual abuse. A Brief Symptom Inventory was used to measure depressive signs and symptoms noted in the previous week.

The findings of this study indicated a mean sexual risk score of 4.52 with no differences noted between the men and women (Morrill et al., 2001). The highest sexual risk factor was failure to use condoms. Of the participants, 34% used condoms, while 44% never used them. Fifteen percent had had four or more partners in the previous 6 months and felt that their sexual behavior was out of control, and 21% had traded sex for money or drugs. Half of the participants had been physically abused, and one- third sexually abused in their lifetime. More women than men reported sexual abuse, women experienced more depression than men, and men had a higher level of alcohol problems than women. Women who reported a history of physical and/or sexual abuse had higher depression scores. For both men and women, depression was associated with alcohol and drug use (Morrill et al., 2001). The results assisted the researchers in predicting a model for sexual risk. A major flaw of this report was the lack of an indication of whether or not the participants had access to a mental health provider in the event that one was needed due to the sensitivity of the study content. Quantitative research has attributed to better understanding of how individuals are affected by sex addiction from a measurable standpoint, but has not provided the personal experience of the affected population. Qualitative research is used to obtain the richness of the topic and for understanding the subjectively experienced phenomenon (Giugliamo, 2006).

Qualitative research. Guigliamo (2006) conducted interviews with 14 men who self-identified as having problems controlling their sexual behavior. One participant was

African American, and 13 were Caucasian; and their ages ranged from 29 to 64. The men were recruited through the snowball method, postings at sexual recovery meetings, and announcements at conferences. Each participant was asked, “How do you currently understand your problem?” (Giugliamo, 2006). Eight emerging themes were noted from the interviews: nature or meaning of the behavior, narcissistic needs, desire for human affection or connection, compensation for feelings of low self-esteem, avoidance of disturbing feelings, reenactment of childhood deficits or trauma, need for power and control, a means to cope with issues of sexual identity/orientation, and libidinal and sexual needs (Giugliamo, 2006). Most participants attributed two or three of the themes to their uncontrolled sexual behavior. Thirteen of the fourteen (95%) reported a history of childhood sexual abuse, which correlated with studies from Gold and Heffner (1998), Carnes (1991), and Johnson, Rew and Sternglanz (2006). Giugliamo (2006) expressed the need to explore the theme “need for power and control” further, as it was uncertain if the men were speaking about internal or external power and whether the control was projected over themselves or others. This exploration is essential, as several authors have discussed the theme “out of control” (Morrill et al., 2001; Opitz et al., 2009). A major flaw with Giugliamo’s (2006) study was the limitation of generalizations as women were excluded, and the participation of 1 African American man with 13 Caucasian men does not support diversity among cultures or races.

In another qualitative study by Turner-Shults (2002), the author interviewed two chemically dependent women about their sexual acting out behaviors, which may have been indicative of childhood sexual abuse or childhood trauma. Both women were recovering alcoholics and had experienced verbal/emotional abuse and possible sexual

abuse during childhood. The link between childhood sexual abuse, chemical dependency, and sex addiction has been well- documented (Giugliamo, 2006; Gold & Heffner, 1998; Opitz et al., 2009; Turner-Shults, 2002). Turner-Shults (2002) noted that sex addicts, like other addicts, come from homes where other dysfunctions such as chemical dependency, sex addiction, and emotional/physical/sexual abuse, occur.

Four themes emerged out of this study: mother as unsafe, tension and stress in the family, isolation, and control through church activity. Mother as unsafe developed as the participants described their mothers while they were in childhood. One woman said, "I was scared to death of my mother… I was just scared of her… I was scared she was going to do something to me" (Turner-Shults, 2002, p. 241). The other participant described the feelings she had towards her mother: "I was angry at my mother for being a drunk. For being a drunk and for being such a pity party and for not being there" (Turner-Shults, 2002, p. 241). These quotes bring meaning to how the individual affected by sex addiction experience fear (Opitz et al., 2009) and distrust (Zapf et al., 2008).

The second theme, of tension and stress in the family, echoes the first theme with the difference of having their fathers and additional family members inflicted emotional and verbal abuse. Isolation was the third theme noted in Turner-Shults's study (2002) and has is also known to be experienced by individuals affected by sex addiction. The last theme, control through church activity, developed as one woman sought to control her out-of-control sexual behavior by participating in her local church. As the aforementioned, lack of control or out-of-control aspect is another well-known characteristic of sex addiction (Morrill et al., 2001; Opitz et al., 2009).

Chapter Summary

In Chapter 2, a description of sex addiction was discussed, along with characteristics of the affected population. The history and development of the concept of 'sex addiction' were surveyed in detail along with examples of quantitative and qualitative research studies from the psychology and nursing disciplines.

Although qualitative studies on sex addiction exist, none have been noted in nursing journals. With this review of the research studies, it is clear how the nursing profession can profoundly impact the affected population. Facilities providing inpatient and outpatient treatment rely on nurses to care for individuals suffering with sex addition. Nurses offer nurturance to the affected individual through nursing interventions appropriate to the person and his or her situation. Initial focus on caring for the individual would be through screening for sexually transmitted infections, treatment of sexually transmitted infections, and screening for concurrent addictions, such as eating disorders. It is important for nurses to be aware that 42% of male and 50% of female sex addicts also have problems with chemical dependency, and that 38% of sex addicts have an eating disorder (Schmoyer, n.d.). After the initial interventions are completed, nurses may help these patients cope with underlying feelings and assist them in obtaining referrals to certified sex addiction therapists (CSAT).

Nurses are responsible for bringing the human value of care to the healthcare system. Nurses' caring is expressed through the nurse-patient interaction. Confidence and faith demonstrated in the nurses' commitment to care are examples of the values experienced by the patient. Through their actions, nurses can show other discipline the meaning and value of care is fundamental to healthcare.

Chapter 3: Methodology

Chapter 3 provides a description of a phenomenological research design of this study, guiding the researcher in discovering the experience of seeking health for individuals who self-identify as sex addicts. Further, the ethical considerations, participants, recruitment procedures, data collection, data analysis, and evaluation criteria are discussed.

Research Design

According to Van Manen (1990), phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. Husserl (1931) asserts that phenomenology is the study of the lived experience of phenomena. In Giorgi's (1989) method of phenomenology, the philosophy of Husserl (1931) is combined with the methodical, systematic critical criteria of science to develop a methodology that supports the researcher in identifying and understanding the meaning units, themes, and overall structure of the experience.

Giorgi (1985) states that "as nursing is not yet a well-founded, fully mature discipline, and that both nursing and nursing's use of phenomenology are in the process of coming into being" (p. 25). According to Giorgi (1985), phenomenology does not solely remain a philosophy for nursing, it is most helpful to nursing as a human science, and philosophy is best used as a subfield. Nursing has focused on phenomenological

inquiry as a research method, in which the interpretive process is used, themes are developed, and the overall structure is created. Phenomenology has been widely used by nurse theorists such as Watson (2002) in nursing practice.

The phenomenological research method of Giorgi (1983) reflects human science and is oriented to discovery. This method of phenomenology entails a careful and systematic description of what is given (Giorgi, 1983). The benefit of this approach is that: (a) it allows a more adequate approach to the nature of the phenomena; (b) brings into focus the presence of the researcher in the process of research; and (c) it calls the researcher back to the value of description and qualitative analysis (Giorgi, 1983). The qualitative phenomenological method was used to discover the lived experience of seeking health for individuals who self-identified as sex addicts. Giorgi and Giorgi (2003) suggest that the descriptive process in phenomenology should answer the question, "what is it like to experience a particular phenomenon" (p. 80).

Nurse researchers have widely used Giorgi's (1983) descriptive phenomenological method (Giorgi, 2000; Koivisto, Janhonen, & Vaisanen, 2002). Giorgi (2000) discusses the confusion that exists in using scientific or phenomenological guidelines while conducting caring research. Distinctions between philosophical and scientific phenomenology were clarified and scientific guidelines were used in conducting caring research. Koivisto et al. (2002) undertook a phenomenological study using Giorgi's (1983) method of analysis to investigate psychiatric patients' experiences in a psychiatric hospital. Giorgi's (1983) method of analysis allowed the patients to describe their experiences of being mentally ill in a psychiatric hospital without losing

the quality of the data. This information gave nurses a new view on meeting the needs of patients with mental illness,

According to Giorgi (1997), the researcher investigated the experience and meaning of seeking health from a phenomenological perspective, giving the researcher a clear view into the lived experience of the individual. Bracketing or epoch occurs when the researcher's preconceptions are held in abeyance, as this ensures researchers do not allow their assumptions to shape the data collection or impose their understanding and construction on the data (Ashworth, 1999; Finlay, 2009). It is natural for nurse researchers to draw on their previous knowledge and clinical practice during the research process, which allows for collaboration with the participants and illumination of the phenomenon (Finlay, 2009). However, Parahoo (2006) believes this can minimize our ability to research the topic thoroughly, as we bring assumptions about it into the research process. Therefore, the researcher will not be as open to understandings and meanings from the participant. Bracketing can enrich nursing research by retaining the objectivity and critique central to the phenomenological method (McNamara, 2005) and allowing the participant's voice to be heard.

Participants of the Study

Giorgi (1985) emphasizes that the most important criteria for choosing participants for a study is that the individuals should have experienced the phenomenon being studied. Therefore, individuals who self-identified as sex addicts were recruited for this study.

The participants in this study were 10 men and women who self-identified as sex addicts. Their ages spanned from 27 to 45 years and older. Six participants were

Caucasian, three Hispanic, and one participant classified his/her ethnicity as other. Five men and women identified their sexual orientation as heterosexual, three as homosexual, and one was bisexual. Another woman described her sexual orientation as heterosexual and bisexual. Five participants were separated/divorced, four were married, and one participant was single. Six participants were employed part-time, two were employed full-time, and two participants were unemployed/retired. Two men and two women completed some college education, two obtained a Bachelor's degree, and two obtained graduate degrees (Table 1).

Table 1

Demographic Data

Gender	Age Range	Ethnicity	Sexual Orientation	Marital Status	Employment Status	Highest Level of Education
Women (n=5)	36- 45 and older	Hispanic: n=1 Caucasian: n= 3 Other: n= 1	Heterosexual: n=3 Bi-Sexual: n=1 Heterosexual/ Bi-Sexual: n=1	Single: n=1 Married: n=2 Separated/ Divorced: n=2	Full-Time: n=1 Part-Time: n=4	Some College: n=2 Bachelors n=2 Graduate: n=1
Men (n=5)	27 – 45 and older	Hispanic: n= 2 Caucasian: n=3	Heterosexual: n=2 Homosexual: n=3	Married: n=2 Separated/ Divorced: n=3	Full-Time: n=2 Part-Time: n=1 Not Employed/ Retired n=2	Some College: n=2 Bachelor n=2 Graduate n=1

Sample Size

Giorgi (2003) suggests that a small sample size of participants is adequate to ensure credibility, fittingness, and auditability. For this study, 10 participants were

enrolled until saturation was achieved. Inclusion criteria for participation in this study included: men and women 18 years or older, individuals who self-identified as a sex addict, understood and spoke English, and signed the consent form.

Recruitment Procedures

A key informant known to the researcher and to some of the members of this "hidden population" described this study to individuals who self-identified as sex addicts. If there was an interest in the study, the informant asked the individuals if they would like more information or to contact the researcher at a cell phone designated for this study. The researcher discussed the purpose of the study and data collection procedures, and efforts were used to assure anonymity and confidentiality with those who called. If the individual chose to participate or not, the researcher asked for other individuals known to the caller who may be interested in participating; thus, creating a snowball effect for recruitment. Snowball sampling is often used as an effective tool when trying to obtain information on and accessing 'hidden populations' (Munhall, 2007).

Data Collection

The researcher and participant scheduled a meeting place that was convenient and comfortable to each party. The researcher collected a signed informed consent, a demographic data, and conducted the interview. During the interview, the informed the researcher explained the study, with the emphasis on confidentiality and possible benefits and consequences of participating. The participant was asked to complete a demographic information tool. The questions consisted of content, such as age, gender, and ethnicity.

A semi-structured interview, lasting approximately 1–1.5 hours was conducted. All interviews were audio-taped with the permission of the participants. If the

participants became agitated or distressed during the interview, the interview was stopped and the individual referred to a counselor. If the participant voiced intent to harm himself/herself, emergency medical services were activated and the researcher would remain with the participant until care was passed to other medical personnel.

After the interviews, the recordings were transcribed and placed onto computer files. The researcher took care to ensure the respondents that they would not be identifiable in any subsequent report. Once the final research report was written, the recordings from the interviews were destroyed.

During the audiotaped interview, open-ended questions and field notes were used to discover the healthcare experiences of individuals who self-identified as sex addicts. The following questions were used to direct the interview:

1. What does the phrase "health-seeking behaviors" mean to you?
2. Tell me about your health-seeking behaviors.
3. How has self-identifying as a sex addict influenced your health-seeking behaviors?
4. How have you been treated by healthcare professionals at your healthcare visits?
5. Have you been hospitalized for conditions related to sex addiction? Tell me about your experience.
6. Have you visited the emergency room for conditions related to sex addiction? Tell me about your experience.

7. What else would you like to share with me that would help me understand your healthcare experiences or others you know who self-identify as sex addicts?

Ethical Issues

Permission was obtained from Florida Atlantic University's (FAU) Institutional Review Board (Appendix A). Participation in this study was voluntary, and an informed consent was obtained before any data collection occurred. Each participant received a copy of the informed consent (Appendix B), which included a written explanation of the study purpose, the involvement and time required, the right to confidentiality and anonymity, right to ask questions of the researcher, and the right to withdraw from the study without detriment to the participant. Emphasis was placed on assuring participants that if declining to participate or withdrawing from the study were to occur, it would be without consequence. Anonymity was maintained by not linking demographics with the individual participants and using identifiers instead of names.

A major role of the researcher during the interview process was to support the participants in describing their experience in a manner consistent with the basic ethical principles as described in the Belmont Report (1979).

Data Analysis Procedures

The data from this study were analyzed using Giorgi's (1989) method that outlines five phases that constitute the descriptive phenomenology. In the first phase, the researcher read the entire description to gain a general sense of the whole statement without analyzing the data. As recommended by Giorgi (1995), the researcher read the descriptions several times to gain an understanding of the experiences.

Once a sense of the whole description was grasped, in the second phase the researcher returned to the beginning of the statement and read it in its entirety. The text was read with the specific aim of discerning “meaning units” with an emphasis on the phenomenon being researched. When the researcher experienced a transition in the meaning of the transcribed interview, that transition was marked and delineated as a meaning unit. The interview was then divided into meaning units. These raw data from the interview were organized into words and phrases used by the participants who expressed a particular meaning within the description of seeking health.

In the third phase, the researcher studied, examined, and eliminated redundancies in the meaning units, clarifying or elaborating the remaining units and relating them to each other. During this process, the researcher translated the language of the participant into a professional language, so the meanings were useful to nursing. It was particularly important for the researcher to remain true to the meanings of the participant while translating the meanings to be beneficial to nurses.

Fourth, the researcher used an imaginative variation to determine which meanings were essential to the identity of the experience of health-seeking behaviors. The researcher imagined all possible variations of the attributes to the experience without losing the true identity of the experience. Attributes not necessary to the phenomenon’s existence were removed (Kleiman, 2004). The researcher reviewed all the units and synthesized them into themes and meaning units.

In the last phase, the final structure of the phenomenon emerged. This overall structure was composed of the essential meaning of seeking health and reflected the individual meaning for each participant (Giorgi, 1985). The general structure that

emerged from the synthesis of the meaning units and themes was the experience of recovery for the individual who self-identifies as a sex addict is working to better self while avoiding the pitfalls of addiction. This final structure allows nurses and all healthcare professionals to understand more fully the experience for seeking health for individuals who self-identify as sex addicts.

Evaluation Criteria

Trustworthiness is an essential element in qualitative research, and the findings of a study should reflect the reality of the experience (Buchbinder, 2011). Lincoln and Guba (1985) described standards of trustworthiness in naturalistic research that Beck (1993) later modified. Beck (1993) proposed credibility, auditability, and fittingness as three main standards of rigor common to qualitative methods in general rather than to a specific methodology. To establish trustworthiness in this phenomenological study, the researcher used Beck's (1993) criteria of credibility, fittingness, and auditability to evaluate rigor.

According to Beck (1993), credibility is a term that relates to "how vivid and faithful the description of the phenomenon is" (p. 264). Credibility was ensured, as the researcher kept a journal during the study, which described reactions to events and allowed for self-reflection. Credibility was also achieved, as the researcher performed member checks at the completion of the study, which allowed participants to comment on the accuracy and truthfulness of the findings (Buchbinder, 2011).

Fittingness was achieved as the researcher supported themes of the study with exemplars and quotes. This criterion was obtained as the data were generated and could

be applicable to additional areas of study out of the context of health-seeking behaviors of self-identified sex addicts.

Auditability was achieved by the researcher audiotaping the interviews and verifying that transcriptions were verbatim (Beck, 1993).

Chapter Summary

In this chapter, Giorgi's (1989) phenomenological approach to discover the meaning of a phenomenon was described and applied to this study aimed at discovering the experiences of seeking health for individuals who self-identified as sex addicts. The research design, ethical issues, data collection procedures, data analysis methods, and evaluation criteria were also described.

Chapter 4: Findings

This purpose of this phenomenological study was to explore and describe the experiences of seeking health for individuals who self-identify as sex addicts. This chapter provides the results of this study. Using Giorgi's (1985) phenomenological analysis method, the descriptions of the experiences of the participants were explored using meaning units. These meaning units were analyzed further, organized into themes, and finally, the themes were synthesized into a descriptive structure of the overall experience of seeking health for the participants in this study. The overall structure is defined as follows:

> "The lived experience of seeking health in recovery from sex addiction is dancing on the outer circle, connected to a community that understands fear, shame, and the struggle to remain vigilant for pitfalls while intentionally refocusing on living an honest life of giving and receiving.

Interviews

Ten individuals who self-identified as sex addicts participated in this study. Open-ended questions focused on discovering the experience of seeking health for these individuals. The participants were five men and five women who attended Sex Addicts Anonymous or Sex Love Addicts Anonymous. They came from various racial and economic backgrounds. The following descriptions provide the day-to-day experience of

seeking health for the 10 participants in this study. Fictitious names are used in the descriptions to protect the identity of the participants.

Descriptions

Olivia. Olivia, a woman with curly, mid-length black hair appeared to be in her early 40s. She was approximately 5'4" in height and was dressed in a white t-shirt, purple sweater, jeans, and flip-flops. We met at a Starbucks on a Wednesday morning and sat in a corner for privacy at a high chair table with bar stools that sat two. After the initial greetings, the study and the purpose of the study were described to the participant. Thereafter, the researcher explained the consent form to her, which she then read and signed, agreeing to the audio-taping of the interview. After the consents were signed, the demographic form was completed, and the researcher initiated the interview.

The study was introduced and then Olivia was asked to describe what the phrase health-seeking behaviors meant to her. She responded, “What do health-seeking behaviors mean to you? Okay. Like recovering maybe? Behavior. Yeah. Needing help. Getting help. I’ve never heard that term used with my addiction at all. I don’t know. Do you want me to expand on that?” She further answered the question as, “think reaching out really is my best way of describing it. That’s what we do in our group. It’s the thought of reaching out – in the 12-step group. Just going is actually health-seeking behavior….”

As the interview progressed, Olivia discussed how sex addiction had affected her marriage and children. With her marriage she talked about how honesty was a struggle for her as she had difficulty opening up to her husband about the addiction. She stated, "because he gets so angry when I talk about anything with addiction…. He has a lot of anger. He doesn't trust me." Olivia feared that if she revealed everything to her husband about her addiction that their marriage would end in divorce. She became passionate, as she talked about protecting her children from her addiction: "I have a family and children and I'm trying to protect them. I don't want people knowing what happened to me and still happens to me." Protecting her children from her addiction also affected Olivia's recovery: "I guess my recovery sometimes gets put on the back burner because of my family/my children."

Putting her recovery on the back burner was also explained as Olivia talked about not attending seminars on addiction recovery, as she had to hide her recovery from her children and others, "I can't just do anything I want." Hiding her recovery was also expressed through "the whole world is covered up. Like before I was covering up acting out and now I cover up my recovery too." Olivia described that society views sex addiction as "molesters, child pornography, and things like that. It's not really always like that." She explained further that because of this societal interpretation, a stigma is associated with sex addiction.

Although she discussed the negative aspects of her addiction, she emphasized the positive aspects to her addiction, such as making lifelong friends in the 12-step groups and connecting with a higher power. A change in her behavior was also attributed to the 12-step group: "I'm more aware of my behaviors because of the program. I'm more

aware, cognizant of when I'm acting selfish or I'm not willing or have the willingness…." The act of protecting was also verbalized again as she felt protected and understood by other members of the 12-step group. Olivia affirmed this understanding by saying, "things we are told all of the time like you're not alone and it's a disease, just like having any other disease."

When asked what else she would like to share regarding her healthcare experience as a sex addict, Olivia voiced the concern of wanting more people being aware, helping, and talking about sex addiction. She explained that individuals affected by sex addiction do not "reach out" because they do not know of anyone to help them and they are "embarrassed" by their addiction. With frustration, Olivia voiced, "and I wish there was more help out there that people talk about that have to do with sex addiction. Like where it wasn't so shameful. It's such a hard addiction I think."

Betty. Betty was a woman with short blonde hair who appeared to be in her 50s. On the day of the interview, she was wearing white linen pants and short-sleeved shirt, navy accented with a navy scarf. She was approximately 5'9" in height with an athletic build. We met at Starbucks on a sunny Saturday afternoon and sat inside at a small table in the back for privacy. Initial greetings occurred and thereafter the researcher explained the purpose of the study and consent forms. Betty read the consent form, signed it, and agreed to have the interview audiotaped. She completed the demographic form, and the interview proceeded.

After the researcher introduced the study, Betty was asked to describe what the phrase health-seeking behaviors meant to her. She said that, "health-seeking behaviors means to me… using the tools in your toolbox and doing things to promote healthy

behavior and recovery." Betty delineated health-seeking behaviors further as, "making the right decisions, choices, making choices, healthy choices, just doing self-care, self-care, and mentally surrounding myself to the right people, the right activities." The incorporation of a higher power in her life was essential to her recovery, and was explained as, "I mean the Man upstairs will love me no matter what I do, what I say."

Sponsoring other women has also helped Betty's recovery and this was explained as, "that too – that a lot of women that I sponsor, which helps me because I see myself where I was engaged in the same behaviors." She added that the 12-step group has aided in her recovery by changing her friend base. "I've been hanging around people that are spiritually more whole and not people that want to just go to bars and pick up men. So I've had a real friend change, which has been life changing."

Betty described her addiction as being "powerless over my behaviors" and "unmanageable." As she started to discuss how her divorce was a consequence of her behavior, she started to cry and requested that we take a break. Betty's voice was shaky as she explained, "I'm just having an emotional morning. I was thinking about my kids and the holidays are coming up." The researcher turned off the tape recorder and listened as Betty described her difficult morning. She sipped on her tea as she dried her eyes and became calmer. As she became calmer, Betty asked to re-start the interview. The researcher asked her if she would like some more time, and she verbalized that she was okay to re-start.

Betty continued by describing an interaction with her gynecologist, in which she encountered a healthcare professional for care related to her sex addiction. She explained this experience as, "My OB/GYN. I had unprotected sex with five men and so I had

myself tested for STDs." At a previous visit with her gynecologist, she was diagnosed with genital herpes. She panicked initially and assumed automatically that she had contracted the virus from one of her current partners. Betty admitted that her fears were relieved slightly when she heard her gynecologist say, "I could have um, had it 20, 30 years ago. It was dormant." Betty then realized that she could have contracted genital herpes from her husband. "He had symptoms about 15 years ago and I didn't know what it was." Another encounter with a healthcare professional was with her certified sex addiction therapist. "The CSAT will really guide your life. He really saved my life." She explained that she did not trust her thoughts, actions, or decisions and gave everything over to her certified sex addiction therapist and expressed her distrust in herself as, "all my decisions got me in the wrong place."

She explained her addictive behavior as "emotional infidelity" as she described how she worked out to become fit and more attractive so that she could get attention. Getting attention was further defined as, "so I could be as flirtatious as I want. I could get – and those are, what we call those hits, right, the attraction to some other men. I could get that attention…." She described her past "lifetime of behavior" as shameful, and stated that, "After 20 years, and when I look back, well, that is completely inappropriate behavior."

When Betty was asked what advice she could give healthcare professionals in caring for individuals affected by sex addiction, she recommended getting the individual a certified sex addiction therapist and sending them to a meeting with a 12-step group, such as Sex Addicts Anonymous. She also encouraged exploring the affected individual's

family history, “I think a lot has to do with my family history… family history and family boundaries.”

Kevin. Kevin appeared to be in his mid-50s, approximately 5'7" in height, wearing a white t-shirt, khaki cargo pants, and flip-flops. The interview was conducted at a Starbucks on a Wednesday evening. The researcher offered to buy the participant a drink, but he kindly declined. The purpose for the interview and the consent form were explained to Kevin. He signed the consent form, declined a copy of the consent, and completed the demographic form. Initially when the interview started, the participant and researcher were sat at a small table for two by the door due to unavailability of other seats. Approximately 3 to 4 minutes into the interview another table became available in a quieter area of the Starbucks, and we relocated.

The study was introduced to the participant and then Kevin was asked to describe the phrase health-seeking behaviors and his reply was concise, “it would mean seeking out wellness.” The researcher asked Kevin to explain further, and he replied, “it would mean being physically, mentally, spiritually healthy. Practicing—good health practices.” He discussed “physically” as practicing good health and “mentally” was highly associated with spirituality. Kevin explained spirituality as, “having a connection with your higher power, with God if that’s your higher power. Surrender, knowing that there’s a – for me, it’s a belief knowing that there is a plan for me….” He also explained spirituality as “doing the next right thing.” When asked to explain that phrase, Kevin said it is “living an honest life.” He described his health-seeking behaviors as, “being very realistic. Being honest, true to yourself.” He explained that, “addicts are manipulators, in which they

manipulate themselves and others." His health-seeking behaviors were further described as "I'm always constantly checking myself, checking my motives."

Kevin spoke about his sex addiction and revealed that his arrest and detention in federal prison for 60 months was a "direct correlation" to the addiction. He referred to himself as a sex offender and explained the daily struggles he has faced. "The only restriction I have is that I'm not allowed to keep pornography in my house whatsoever and then I can't be around children." He also explained that he lives on a block with seven other offenders and on Halloween, he is on lockdown at home with shades down and lights off. He expressed this constraint as, "everything worked out the way that it was supposed to. But the fact is that, you know, this is my life." Prior to his arrest, Kevin did not identify himself as a sex addict and stated, "I wasn't honest about it." He admitted that he lived a lie and that he would have never acknowledged the addiction. While incarcerated, he recognized his addiction and "took full responsibility".

Kevin contributed his family history of verbal abuse directly to the addiction and called it "emotional incest." Kevin admitted that during his teen years he always knew that something was not right. "I'm talking about from late teens. I was addicted—there had been tons and tons of pornographic magazines under the bed, it was awful then. I lived a life of bondage, true bondage." Kevin explained how sex addiction controlled his life and affected significant relationships with his children and wives. He also described how often, "You know, I mean I had sex on the mind 24/7 maybe not 24/7 but maybe 22/7. You know, but it affected my entire life, it affected my work."

Kevin has had interacted with healthcare professionals for his sex addiction, as he was court-ordered to see a therapist after being released from prison. He explained that

the mandated group therapy was not very helpful and desired to get a personal therapist when he obtained health insurance and was capable of getting his own therapist. Kevin discussed how he has been in and out of therapy his whole life and described it as, “I think any type of therapy is beneficial once you keep an open mind.”

When Kevin was asked what else he would like to share about his healthcare experience as a person who self-identifies as a sex addict, he voiced, “I think there is such a huge misunderstanding of sex addiction, yes, the pervasiveness of the addiction. Now it affects so many aspects of your life that it’s misdiagnosed.” He recommended that healthcare professionals “be compassionate, be non-judgmental” when caring for one affected by sex addiction.

Howard. Howard was approximately 5'7" in height, appearing in his late 50s with dark grey hair and wearing a plaid shirt, jeans, and sneakers. The interview took place at Fresh Market on a late Wednesday afternoon. We sat outside at a table with two chairs and an umbrella that provided shade for both of us. The outside speakers played jazz music in the background during the interview. After the researcher explained the study and the consent form, Howard read and signed the consent form and agreed to have the interview audio-taped. As the participant did not have any questions regarding the study or the consent form, he then proceeded to fill out the demographic sheet.

The first question of the interview asked Howard to describe the phrase health-seeking behaviors and he replied, “Behaviors that contribute to my emotional, physical and spiritual well-being.” Howard discussed the emotional aspect as “trying to stay in an appropriate position as far as feelings go no matter what the situation is. Not trying to feel too high or too low.” Physical aspect was depicted as going “to a trainer three times a

week. I have diabetes and I check my blood sugar every day, I go to the doctor… regularly. I go to the dentist when I need to go." Having a higher power was described as essential to his spiritual well-being.

Howard explained how important Sex Addicts Anonymous had been to the success of his recovery. He described how becoming aware of his addiction led him to a 12-step group. "Once I became aware of it, it started me on a 12-step program which has changed my outlook and behavior in life." Howard later explained that attending Sex Addicts Anonymous had helped him to get out of isolation and become "socially integrated in all aspects of life." Asked by the researcher to explain "all aspects of life," he described them as everything "from driving in a car to having a simple conversation with a man on the street. Anything. In other words, trying to be present and in the moment."

Sex Addicts Anonymous has fostered changed behavior in which Howard no longer "lives a double life," and he talked about triggers to others in the group instead of hiding them. Howard also attributed sponsoring others in the program to his changed behavior. He expressed this as, "I think doing service is perhaps the highest thing a human being can do. It fills up a hole inside of me. Makes me feel meaningful and satisfied and full of grace."

When asked about recommendations for healthcare professionals in caring for individuals affected by sex addiction, Howard encouraged them to become familiar with the 12-step groups and not to be judgmental while caring for the affected individual. He also recommended that the healthcare professional help the individual affected by sex addiction to create a structured life. Howard described this essential fact as,

> "Informing them that unaccountable time is dangerous. There needs to be a structure in one's day…. If there is just hours going on where somebody doesn't really have to do anything or answer to anyone it is a high risk situation."

Eva. Eva was a woman with blonde hair who appeared to be in her mid-40s, approximately 5'4" in height, and dressed in a light-colored floor-length dress. The researcher went to Eva's place of employment for the interview, which was a self-owned massage parlor. Light music was playing in the background and candles were lit all around the building. The researcher described the study and consent were described to Eva. After she signed the consent and agreed to have the interview audiotaped, she completed the demographic form. Eva did not have any questions regarding the study, consent, or demographic form.

Upon start of the interview Eva was asked to describe the phrase health-seeking behaviors. Her description was expressed as, "health-seeking behaviors… well I believe that's looking for ways to take better care of myself. I like to collect books, reading, and speaking with others." After explaining her health-seeking behaviors she described how the 12-step group had affected her recovery. "Being in AA did not help me address any of my issues. It wasn't until I went to SLA that I started experiencing some type of feeling. SLA helped my personality to go to a deeper level." The researcher then asked Eva to explain the meaning of a deeper level. She stated, "you get to experience your feelings around what you think you love, what you believe is love."

Sex Love Addicts Anonymous also helped Eva realize the level of emotional involvement with people. She described this as, "now when I say I've got to let that guy go, obviously, he's an avoidance addict or whatever you want to call it, I used to work

very hard at making those people feel better." Eva explained that now she does not take it personally anymore, and her drive to fix others has changed since she "stopped doing those things."

Eva explained how multiple sexual relationships were not good relationships. She revealed this as, "It was all based on sex and instant gratification, thinking that you're being loved because you were in physical proximity to a male isn't true. It isn't true." She explored her past, as she says, "I used to think it was normal to have as much sex as I could have. I felt like that was a fun thing to do - and drinking, you know, on top of it." After making this statement, Eva's voice lowered, as she explained how this type of behavior "can get you killed and one can be lost forever."

Eva contributed her dysfunctional family as the cause of her sex addiction. "My mother left when I was very young. She was horrible. She was just mean and sick. And my mother was an alcoholic, too." The need for a role model in her life was expressed as, "when you're a kid, you'd want to look up to your parents. So you don't want to become either of them, I knew that right off." She described her father as,

> "He had girlfriends all over the place. And talk about sex addict. Kids aren't supposed to see this stuff. And then the grown man and just all weekend long, you know, he's hopping on this one and that one and drinking and drinking and drinking."

Eva's encounters with healthcare professionals included a homeopathic doctor, an Indian woman as a gynecologist, and a mental health nurse practitioner who prescribed lithium to maintain her psychiatric disorder. In the past, therapists had seen her for sex addiction, but she described the experiences as unsatisfactory: "I went to a lot of

therapists and none of them helped me. As a matter of fact, I was helping them." She further described her therapists' interactions as, "So after a while, we'd be fixing them. I'm like, this is crazy."

The researcher asked Eva what else she would like to share about her healthcare experience as a sex addict, and her responses were recommendations for healthcare professionals caring for individuals affected by sex addiction. She encouraged healthcare providers to hear out their patients as they have a hard time expressing their feelings. Then Eva recommended letting the patient open up "think of it as purging their grief and their unhappiness and their digest and their toxicity about everything for the reason that they have shut down in the first place."

Glen. Glen was a thin man approximately 5'11" in height with short black hair, wearing white dress pants, a black shirt, and black shoes. The interview occurred on a Tuesday evening at Panera Bread, which had a moderate crowd and light background music playing. We sat at a table in the corner away from the crowd, where the background music was playing softly. The researcher explained the study and consent form to Glen. He read the consent form carefully, signed it, and agreed to have the interview audio-taped. Thereafter, Glen completed the demographic form and without any questions, the interview began.

After the researcher introduced the study, Glen was asked to describe the phrase health seeking behaviors. Initially, Glen did not understand the question, and the researcher encouraged him to take his time in answering. After a few minutes, he answered, "I do a lot of things to maintain my health." He expanded on his answer by saying, "I eat healthy; I do exercise and work out. I try to lower the stress, I take

preventive medicine and like check out for everything to – STDs to cancer check-ups." Glen explained, in general, he is typically healthy except for the sex addiction.

His interaction with healthcare professionals included weekly, hour-long sessions with a therapist for the addiction and regularly scheduled appointments with his dentist, skin doctor, and primary care physician. Glen has been in and out of therapy from 18 years of age and explained that his family started him in therapy due to his homosexuality. The benefit of his current therapy sessions was expressed as, "I connect myself more with the feelings and more with my feelings and doing therapy when I can see myself in a more clear light." In addition to therapy, Glen also attended 12-step groups and has read literature on sex addiction, which has aided in his recovery.

Glen revealed that he undergoes sexually transmitted infection testing once a year, but in the past completed the screening sometimes once a month due to his sexual behaviors with the addiction. Glen explained that a consequence of his past sexual behavior has led to contracting sexually transmitted infections, such as gonorrhea, Chlamydia, genital herpes, and pubic lice.

Glen occasionally had sexually transmitted infection testing completed with his primary doctor, but mainly had the testing done at anonymous sites for privacy. He revealed "feeling ashamed and vague on the details" of his sexual activity since his primary care physician was a female. He stated, "Maybe if she was male or probably she was gay like me probably would be best." Glen also discussed how living with sex addiction was like "living a double life." This was described as

> “Something that you hide in your own house, with your partner or your spouse or your sons, or with your children, with your parents, with your relatives and it’s something that you hide so much that, you almost believe the lie.”

When asked about additional healthcare experiences to understand individuals affected by sex addiction better, he recommended that healthcare professionals be more approachable. He also suggested providing pamphlets and additional information on sex addiction and therapy. This information may include “a 12-step program, a website, can be a referral, can be an online meeting by Skype or a telephone meeting.”

Clarence. Clarence was an older man who appeared to be in his 60s, approximately 5'7" in height with grey hair. He was wearing shorts, a white graphic T-shirt, and sneakers. This interview took place in a busy Starbucks on a Friday afternoon. Background music was playing, but was difficult to hear over the activity in the establishment. Although it was busy, we were able to sit in a corner where two tables were connected and four chairs were seated around the tables. The researcher explained the study and consent form to Clarence. After he read the consent form and approved the taping of the interview, Clarence completed the demographic form, and we prepared to start the interview.

The interview was initiated with the researcher asking Clarence to describe the phrase health seeking behaviors. He replied, “Well, in sex addicts anonymous we have what we call outer circle behaviors. It can be anything that occupies your time so that you're not thinking about your addiction or having obsessive thoughts. That’s on one level.” Clarence further explained the other level of health-seeking behaviors as, “an even more positive level of health seeking behaviors where you are actually working against

your addiction." He explained that some outer circle activities, such as spirituality, enhance one's recovery. As he started to talk about his recovery, he became emotional and started to get teary eyed. The researcher offered to stop the interview, but Clarence declined and desired to continue.

Spirituality was an essential component in this part of Clarence's life and was described as necessary to his recovery. "For me, Buddhist meditation is very meaningful and definitely enhancing. I would say crucial, essential for my sobriety." Also vital to his recovery was having supportive friendships from others in his 12-step group. Clarence described this support as, "and identifying that also allows me to be part of my group and to feel a common bond with people who all have the same problem and are trying to recover." He expounded this significance as, "I don't feel alone. I don't feel that I'm unique. Together—they say that it's a "we" program. It's not an "I" program. Together we stay sober one day at a time."

Clarence explained that a contributing factor to his sex addiction was the emotional and physical abuse that occurred when his brother became aware of his homosexuality. He described his addictive behaviors in the earlier years as in "my 20s, during the 70s, I was like a gay disco, San Francisco, California here. I was very much into drugging, going to the gay discos, and cruising, and I was relatively promiscuous." Clarence explained sex addiction as "being difficult" and "powerful, as sex is a necessity." He added, "In sex addiction, there's a much higher rate of recidivism than there is in alcohol and drugs."

In conjunction with the 12-step group, Clarence was under the care of a therapist for his addiction. He described a positive aspect of therapy as, "in therapy you not only

maybe learn the possible why of things, but you also learn how to improve your emotional life and your behavior." With a history of hypertension, Clarence is also under care of his primary care physician, and stated: "but he knows I'm a drug addict and alcoholic. He knows I have problems with sex because I asked him for an HIV and I was negative. And he knows I'm gay." When telling the primary care physician about his addiction history, Clarence was apprehensive about the feedback he would receive, but said his doctor accepted it. He explained that he viewed his primary care physician as an authority figure, and expecting prejudice was clearly a projection on his part. Later, Clarence explained that shame is involved with this addiction and during the interaction with his primary care physician, realized it was more of a problem for him than for his doctor.

When asked about any recommendations for healthcare professionals in caring for persons affected by sex addiction he suggested finding a therapist and a support group. Clarence stressed the fact that with the nature of the disease, if the person "wants to recover they have to change their life completely. They have to make a clean break with the past, start a new life."

Leon. Leon was a man who appeared to be in his 60s, approximately 5'9" in height, wearing a denim jacket, white polo shirt, jeans, and rowboat shoes. We met at a Starbucks on a Friday afternoon and sat at a side table away from the crowd. After the greetings, the researcher explained the study and the consent form. After Leon signed the consent form and authorized audio-taping of the interview, he completed the demographic form, and the interview began.

Describing the phrase health-seeking behaviors was the first question asked of the participant, to which Leon responded, “No idea. Never heard of it. First time I have heard health seeking behaviors.” A few minutes after the interview started, Leon asked if we could speak a little quieter, and the researcher easily obliged. He returned to the question asked of him and replied, “Looking for things that are beneficial to you… spiritual as well as physical or emotional.” “Physical” was described as eating healthy, exercising, and annual doctor examinations. “Emotional” was explained as, “coming to terms with myself and who I am” and staying in the present, which is “robbed by addiction.” When discussing the spiritual aspect, Leon talked about the importance of a higher power and revealed that he had always been a very spiritual person.

As Leon is strong in his spirituality, he believed it was essential to pass on his experiences to other members in the 12-step group so that they would not “go through what I have been through.” He further explained this fellowship as, “no other person can provide the support to an addict like another addict.” Leon found familiarity in the program, as others in the room spoke his thoughts despite their age, marital status, or race. He explained the 12-step group was “just a whole different animal”, and has different principles in all 12 steps, which is “like taking baby steps.”

Leon was introduced to the 12-step group, as he initially went to the meeting to get help for his partner’s gambling addiction, but was acting out sexually to cover up his partner’s actions. After 2 months of attending he realized that he needed help and that he was “emotionally broken.” Leon revealed that shortly after joining Sex Addicts Anonymous the program opened his eyes and being introduced to a 12-step group led him in the right direction.

Leon attributed family abandonment in his childhood as the cause of his sex addiction. He described his mother as an alcoholic and a sex addict, and said that his father left him when he was 2. Further abandonment occurred when his mother left him in the care of his great aunt and great uncle, who consciously attempted to turn him against his mother. The emotional abuse had left him with "the core belief that I am worthless" and belonged to shame and guilt. Leon explained that, "your emotional roles 'freeze' when you are affected by sex addiction and they just become stuck. Leon described the insanity of addictions was described by the participant as "being overly protective of himself" and then the "boundaries of his life kept expanding until everything was at risk." He explained that sex was used as a tool to manage emotions. Leon further explained that sex addiction was a survival behavior. Without it he "may have died or committed suicide." It kept him safe.

Leon told the story of his primary care physician's difficulty in diagnosing his depression. When it was diagnosed, he was prescribed antidepressants and started in therapy in which "things improved." When he started talking to his therapist he realized how little they were aware of sex addiction. Leon described this discovery as, "It's like if you're going to go and see a doctor and the doctor doesn't know about aspirin."

When he was asked about recommendations to healthcare professionals, Leon explained that there are several components to the individual affected by sex addiction, such as childhood trauma, dependency, and so on, and when providing care all areas must be understood fully to provide acceptable care. He also recommended being non-judgmental "we get judged enough." By non-judgmental, he explained as being understanding and gentle. Being judgmental could impose pain, guilt, and shame. Leon

said, “You don’t want to introduce more pain. It doesn’t work. It has never worked.” The researcher asked if there was any additional information that Leon would like to share, and he verbalized no.

Annabelle. Annabelle was a woman appearing in her mid-40s, with long black hair, approximately 5'8" in height, and wearing a black dress and heels as she had just come from work. We met at Starbucks on a Friday evening and sat at an end table, where the interview was unlikely to be distracted. Once the greetings were complete, the researcher explained the study and consent in detail to Annabelle. After she read the consent form and gave approval to have the interview audiotaped, Annabelle completed the demographic form and the interview began.

Annabelle was asked to describe the phrase health-seeking behaviors, to which she answered, “For me it is going to meetings, being honest and not falling into the pitfalls that trigger me into acting out.” She explained that without the meetings she could not be honest with herself about sex addiction. “I could pretend that I am not a sex addict.” Annabelle further explained that “avoiding pitfalls” requires self-knowledge of what will initiate her acting out. She described her pitfalls as “I do not like to feel pain, rejection or failure.”

Annabelle portrayed honesty as being essential to her recovery: “Being honest. It is part of self-awareness.” The researcher asked for additional detail on self-awareness, and Annabelle stated, “For example, I am somebody that needs a lot of clarity.” She explained further that clarity is needed, whether she is just “hanging out” or actually dating another person.

Annabelle discussed how the 12-step meetings are also vital to her recovery and revealed “sometimes you can share the meetings, just keeping connected to the program and to the movement. I’m kind of incorporating others into my recovery when I do that.” Being in the meetings allows her to feel like she is not the only woman in the world affected by sex addiction and is not “by myself.” While attending the meetings, Annabelle noticed a scarcity of women-only meetings, and so she began to initiate this process. She described starting a women’s meeting as “service” and explained that, “doing the meetings, doing service makes me feel like I am a part of something bigger.”

Prior to attending meetings for her recovery and desiring to start a women’s only meeting, Annabelle revealed, “my view of women has been that they have been either a competitor or an obstacle, which I am not in that space anymore.” She explained further how she has become more compassionate to women. “When I encounter other women that have struggled, I am not quick to judge or just dismiss them because they are being – what is the word? – because they are being drama queens or whatever.”

Annabelle is not “quick to judge” others, as she has experienced being judged by healthcare professionals. She explained one experience as she sought care from a nurse practitioner at a clinic in Key West for screening of sexually transmitted infections. She described the nurse practitioner as “very reserved. I felt judged because I went in for an STD panel and they ask you what is your highest level of education and I am like oh, graduate degree.” She explained further what society expects: “You do not expect that from an intelligent educated woman. You expect that from the Neanderthals with no resources or education, right.” Overall, she described that the nurse practitioner “did not admonish me or anything,” but Annabelle felt the provider judged her.

Another experience for Annabelle occurred when she was younger and was seen by a physician who was also a friend of the family for an anal injury. This injury was a result of an accident during intercourse and was described as “passionate – it slipped out and went in the wrong way… it was very painful.” Annabelle expressed her encounter with the physician as, “he examined me and dismissed me as a whore that was practicing anal sex.”

Annabelle also knew other individuals affected by sex addiction who have experienced embarrassment while seeking care. She explained that she had “heard of stories of objects being lodged in places where they could not come out,” and that as the person presented for treatment, they heard interns “laughing or making a joke.” Annabelle expressed that this is “horrifying” and “that would be mortifying if I was that patient. That would be awful. Those curtains are not soundproof. That’s a myth.” Later she explained that healthcare professionals should be aware that “if somebody comes before you as a patient, they are in your hands and that should not be treated lightly or irreverently. I think it is a huge responsibility but everyone deems respect.”

When asked about recommendations to healthcare professionals in caring for a person affected by sex addiction, Annabelle commented, “I would ask them if they are seeking help. That would be my first question.” She also recommended offering handouts that contain contact information for therapy. At the end of the interview, she said, “The addiction is so powerful and that is the thing that education does not matter, race does not matter, economic status does not matter. This thing will get you no matter who you are. It knows no boundaries whatsoever.”

Kim. Kim appeared to be in her mid-40s, approximately 5'3" in height, and dressed in a black top, black pants, and black heels. The interview took place at Panera Bread on a late Friday evening, where the crowd was busy but settling down and the background music was playing at a moderate level. Greetings occurred between the researcher and Kim. Subsequently, the researcher explained the interview and the consent form. Kim signed the consent form, gave the researcher permission to audiotape the interview, and completed the demographic form. The interview began thereafter.

Kim was asked to describe the phrase health seeking behaviors, to which she replied, “health seeking behaviors, so you go to the doctor and get a checkup.” She expanded on the answer by articulating, “And also like seeking help if you have an addiction, seeking help, which is health.” Her health-seeking behaviors consisted of, “I exercise regularly, I eat well, I attend several 12-step programs several times a week.” An essential health-seeking behavior was developing “rules that I come up with myself.” These rules were described as, “to have feelings for the person that I’m going to have sex with instead of just having sex for feeling insecure and to medicate myself with is basically what I did is medicate myself with sex.” The researcher asked Kim to expand on the meaning of “medicate myself with sex.” She explained the term as,

> “It made me feel like I had power over men like men were in love with me and I can get whatever I want, get them to do whatever I want. I would be proud of the fact that I could get any guy that I want. It was a real big ego trip….”

Medicating was further verbalized as, “I would medicate – if I was scared, sad, lonely, anything that I felt bad and I would also use it if I broke up with a guy or if a guy cheated on me I would use it to get even. I would use sex as revenge….”

Kim continued to describe her behaviors as, “I got addicted to those internet dating sites like Plenty of Fish and stuff. And I would be like, what flavor do I want tonight, Italian, Cuban? Ha, ha, ha, thinking it was all a big game….” Although dating men became a game to her, she fell “in love with some of the guys.” If these relationships did not materialize, she became heartbroken and experienced emotional withdrawal from the men. Kim explained the withdrawals as,

> “And I would get the shakes like I had to drink. My hands would start getting shaky. I couldn’t think. I was sweating all the time. I couldn’t work. I was a wreck. I was just a train wreck, emotional train wreck. It was awful.”

Kim also explained that she had a “go-to guy” that she made contact with when she needed her “fix.” She later revealed that she contracted Chlamydia from her “go-to guy” and was treated at the Indian Health Service clinic. She reported that the staff at the clinic treated her “really well.”

Kim explained how she encountered physical and sexual abuse during her lifetime. She could not explain details of her sexual abuse, but revealed that she had started experiencing “significant dreams” and “having memories of sexual abuse that happened to me.” Kim described the abuse in her first marriage as, “my husband was very abusive, physically abusive to me, very physically abusive.” She related her abusive relationship with her husband to the abusive relationship that she had with alcohol.

> “I suffered the exact same consequences as I did to this man and I’d end up getting my ass kicked by alcohol. I was getting my ass kicked by a man. I put down the alcohol. When I was married I didn’t drink those years. But I was getting my ass beat.”

Although she was divorced from her husband, she went back to him "three times" until he kicked her in the head, and she said, "I'm done. I'm through. I did what I needed to do."

Due to her abusive marriage, Kim started attending the support group "women against violence." This was her first interaction with a 12-step group. Women against violence helped her to recover from her abusive relationship and Alcoholics Anonymous helped her to recover from alcoholism, but they did not help her with "male addiction." Kim described what she was seeking from men

> "And every time I'd get a guy that will love me and care for me it's not what I'm looking for. It's not filling up that emptiness that I feel inside. And I think that's going to fix it but it doesn't. It never fixes it."

This made her to realize that "the problem is me," and that was when she sought help from Sex Addicts Anonymous. "It was really an incredible, very powerful program."

Alcoholics Anonymous helped the participant to see the significance of spirituality. "I love it because people in AA are really spiritual." Kim explained how members of Alcoholics Anonymous use the metaphor "peeling an onion" to describe sobriety.

> "That metaphor, the onions, that's how sobriety is – it's like peeling an onion. You have to keep going. You have to keep going. So maybe God was helping you peel your onion, you need to have more layers you need to peel."

As her higher power, God was described as being essential to Kim's recovery. "God let me know you're helping me, let me know you're helping me, just let me know you're helping me and I'm going to try to stay sober." She also stated, "This is God. This

is a fun thing. This is how God works when I allow him to. This is what I learned in the program."

When asked about recommendations for healthcare professionals in providing care to individuals affected by sex addiction, Kim encouraged directing the individual to Sex Addicts Anonymous. Secondly, she suggested giving the individual as much information as possible on sex addiction and to give them a questionnaire. Lastly, Kim strongly recommended that abused women be directed to Sex Love Addicts Anonymous. The purpose of this last suggestion was explained as,

> "If they don't find a man who beats on them again, they keep ending up in the same cycle. That's love addiction, because if they find a man who doesn't beat on them they'll find a man who'll cheat on them or they find a man who's an alcoholic or a drug addict. That's love addiction, codependency and love addiction."

Data Analysis

Themes and meaning units. This study was conducted to understand how individuals that self-identify as sex addicts perceive and describe their experiences of seeking health. The analysis focuses on the overall statements made and the essences of the participants' experiences of the phenomenon of seeking health. Themes such as connecting with others and being vigilant are revealed.

The five phases of Giorgi (Giorgi & Giorgi, 2008) guided the data analysis process in this study. In the first phase of data analysis, the researcher read the participants' entire narratives to obtain a general sense of the data. In the second phase, the participants' experiences were illuminated, and the researcher read the interview

transcripts to seek commonalities among experiences. The data were read thoroughly again and meaning units were developed (Giorgi, 1979). A list was made of the participants' non-repetitive, non-overlapping statements. This formed the meaning units of the experiences of the individuals interviewed. Although some sentences could have been labeled as a meaning unit for any given participant, the researcher was looking for a cluster of at least two or three sentences that would form a meaning unit for the individual participant, as well for all participants. Field notes supplemented the content of semi-structured participant interviews.

Bracketing was also completed in this phase as the researcher purposely avoided prior assumptions and knowledge about health seeking behaviors and sex addiction and relied on the words of the participants to describe their perceptions and experiences to develop meaning units. According to Dahlberg, Drew, and Nystrom (2001),

> Researchers must restrain their pre-understandings and encounter data in an unspecified and open manner as possible. When the researcher remains true to the data and suspends pre-understanding, the result is a description of the phenomenon as it appears, as it shows itself to the researcher, with nothing taken for granted about its "real" existence. A pure description of the phenomenon is in this sense, a description of its meaning, based on the experience of "the thing." (pp. 183–184)

In the third phase, meaning units were examined, redundancies were eliminated, and the units were clarified and/or elaborated. The researcher looked for invariant features of the phenomenon, and the ordinary language of the participants was transformed linguistically. Phenomenological analysis, through data reduction, seeks to elucidate the meaning, structure, and essence of the lived experience of a phenomenon for a person or group of people (Patton, 2002).

In the fourth phase, the researcher determined which meanings were essential to the identity of the phenomenon experience of seeking health. In this phase the meaning units and themes were synthesized into consistent structures.

In the last phase, the researcher read the interviews and meaning units and themes several times to gain the overall understanding of the participants' descriptions of their experiences. An overall structure was synthesized with all meaning units and themes regarding the participants' experiences.

During data analysis, the researcher created charts to identify the ideas and transitions of the data easily (Table 2). On the initial analysis 12 meaning units and eight themes were synthesized with 115 participant statements. The second analysis revealed eight meaning units, five themes, and 81 participant statements. The last analysis revealed 10 meaning units, five themes, and 86 participant statements. The following shared meaning units and themes emerged during the final data analysis process:

A Connecting with Others:

1. Reaching Out,
2. Seeking Shared Understanding, and
3. Connecting with Your Higher Power.

B Managing Stigma:

1. Revealing Concealing.

C Integrating the Past for Recovery:

1. Reflecting Triggers, and
2. Overcoming Powerlessness.

D Being Vigilant:

1. Intentional Refocusing, and
2. Living an Honest Life.

E Giving of Oneself:

1. Informing Others, and
2. Doing Service.

The following meaning units and themes are defined with examples from the participants' stories.

Table 2

Thematic Progression

Analysis	Meaning Units	Themes	Participant Statements
First (initial)	12	8	115
Second	8	5	81
Third (final)	10	5	86

Connecting with others. *Connecting with others* described the participants' needs to be with others with the same struggles, as it brought comfort and created bonding. The participants expressed that this is vital for individuals affected by addiction to maintain recovery. Leon described the connection as "It's a common language." Clarence voiced, "I just feel that they care about me, that they have my best interest at heart." As addiction is a disease of isolation and disconnection, recovery incorporates connecting with others with the same experiences. Annabelle discussed the importance of connection and recovery: "just keeping connected to the program and to the movement. I am not by myself; I'm kind of incorporating others into my recovery when I do that." The daily

experience of connecting with others was also best understood through the context of the meaning units reaching out, seeking shared understanding, and connecting with a higher power.

Reaching out. *Reaching out* emerged as a meaning unit of *connecting with others*, as the participants discussed their day-to-day life of connecting with others, such as healthcare providers, to maintain their recovery. Olivia explained that reaching out to others in the program Sex Addicts Anonymous helped her challenges with recovery. "I think reaching out is my best way of describing it. That's what we do in our group. It's the thought of reaching out in the 12-step group." Betty and Glen reached out to therapists to help with their struggles with addiction. As a sex addict, Betty expressed the importance of having a therapist, "a certified sex addiction therapist because they get us. So the CSAT will really guide your life. He really saved my life." Betty's viewpoint on therapists was congruent with Glen's, as he revealed, "Yes, the therapy helped is something that – when I realize I described myself as sex addict I also break the fantasy – I connect myself more with the feelings…"

Eva also reached out to a healthcare professional, but sought help from psychiatry, as she needed medication to aid in her recovery. She described how the medication has changed her life:

> "Because lithium's just a mineral. It's not a big deal. She gave it to me. I have never felt bad since then about anything. I was shocked. I thought if I had had this at seventeen, I would've had a completely different life."

Leon expressed his interaction with the psychiatrist from a positive aspect, "when I went to see the psychiatrist actually I got put on antidepressants and on therapy and

things got better." While Clarence expressed this interaction as a routine care, "I see a psychiatrist every four months very briefly just for medication management."

As Annabelle had worked in the field of acupuncture, she used other therapeutic modalities, such as acupuncture and Chinese medicine, to aid in her recovery. "I had a lot of sexual energy, and I did not want to act out, I was trying to release it through Chinese medicine and through acupuncture."

Seeking shared understanding. *Seeking shared understanding* evolved as a meaning of *connecting with others*, as the participants expressed that support and understanding from others is essential to the success of individuals in recovery from sex addiction. Leon believed firmly that only addicts could understand each other: "Okay, no other person can provide the support to an addict like another addict." Olivia described understanding from a connection viewpoint: "It's so protected and everyone understands you. It's just different." Clarence's experience reflected Olivia's standpoint: "Identifying that also allows me to be part of my group and to feel a common bond…"

Connecting with a higher power. *Connecting with a higher power* emerged as a meaning unit of *connecting with others,* as the participants described the significance of how impacts their recovery from sex addiction positively. Olivia, Betty, and Howard discussed the importance of having a higher power in recovery. Betty referred to this connection as, "I mean the Man upstairs will love me no matter what I do, what I say…." Clarence's connection with his higher power was through Buddhism and explained "For me Buddhist meditation is very meaningful and definitely enhancing. I would say crucial, essential for my sobriety." Leon related this as a self-connection: "Basically it is coming into terms with myself and with my higher power actually with the universe. That is who

my higher power is." Kim explained the influence of God as her higher power "This is God. This is a fun thing. This is how God works when I allow Him to."

Managing stigma. *Managing stigma* developed as a theme, as participants' verbalized feeling stigmatized by others in society. Awareness of this stigma has created a sense of shame and difference within these individuals. Olivia described her experience with stigma as: "There's just such a stigma with it. People hear the word sex addiction and a lot of people think its molesters, child pornography and things like that." Betty described the stigma between a man and woman affected by sex addiction: "I just think women are more secretive and more – there's a stigma that a man can be a sex addict, prostitute addict…"

Glen, Clarence, and Leon shared experiencing shame as an individual affected by sex addiction. Glen explained being ashamed of addiction: "Still a lot of people that's ashamed of the stuff so for some people it's harder to discuss than others." Clarence described this experience as "there is still a lot of shame associated with the label." Leon explained self-shame: "And at the same time also feeling that since I belong to this shame and guilt – to this person also I am shame."

Annabelle portrayed the feelings of shame and embarrassment experienced by persons affected by sex addiction in a healthcare setting. This was depicted as, "How horrifying to hear interns or somebody laughing or making a joke. That would be mortifying if I was that patient. That would be awful. Those curtains are not soundproof. That's a myth."

Revealing/concealing. *Revealing/concealing* emerged as a meaning unit of *managing stigma*, as the participants described their need to lie and hide their addiction

and/or recovery to protect themselves and others. As a person affected by sex addiction, being untruthful lead to the development of shame and mistrust. Olivia described this as: "The whole world is covered up. Like before I was covering up acting out and now I cover up my recovery too. I live in two very different worlds." She also explained that protecting her children from her addiction was a necessity: "I have a family and children and I'm trying to protect them. I don't want people knowing what happened to me and still happens to me." Kevin expressed: "I lived a lie. A total lie for once in my life." Glen discussed the experience of hiding and living a double life:

> "And it's something that they – it leads you to a double life. Something that you hide in your own house, with your partner or your spouse or your sons, or with your children, with your parents, with your relatives and it's something that you hide so much that, you almost believe the lie."

Integrating the past into recovery. *Integrating the past into recovery* developed as a theme, as the participants reflected upon their past addictive behaviors and on how that has influenced their recovery. Olivia and Kim discussed emotional attachment as an aspect of their addiction. Olivia stated that, "Mine's more like an emotional thing because I usually attach to one person and act out and then another person and act out." While Kim revealed, "And so what I did to finally get him off my mind was I went out looking for another guy to replace him. And this was the pattern that I had." Howard described the effect of an emotional imbalance: "issues of one's past that create discomfort, restlessness, stress, fear, and an imbalance in one's emotional life and at a young age, usually, the person has learned to escape and seek relief through sexual, compulsive behaviors."

Abuse and neglect were also common factors among the participants. Kevin discussed his history in terms of physical and emotional abuse: “My father was verbally abusive to me and my mother being, I call it emotional incest.” Clarence explained his past encounter with emotional and physical abuse: “I had a brother who was extremely, obsessively homophobic and who abused me emotionally and one time physically pretty badly when he found out that I was gay.” Eva experienced parental neglect: “My mother left when I was very young. She was horrible. She was just mean and sick. And my mother was an alcoholic, too. Both of them were alcoholics.”

Reflecting triggers. *Reflecting triggers* emerged as a meaning unit of *integrating the past into recovery*, as the participants described the factors that initiated their addictive behaviors. Leon described how he was using sex was used as a coping mechanism:

> “We have learned to control sex as a tool to manage our emotions… maybe it is this is such a survival behavior. If I didn’t have that behavior I really might have died, might have committed suicide, might have done something because it kept me safe.”

Experiencing pain, failure, or rejection was a trigger for Annabelle. An example of failure was expressed as, “I failed my boards and I texted my ex acting out partner that I felt terrible and I needed to feel better. He was a very willing participant.” Kim explained that she medicated with sex when “I would feel scared or I would feel unlovable or unwanted. The attention that I got from men made me feel desirable and made me feel powerful.”

Overcoming powerlessness. *Overcoming powerlessness* evolved as a meaning unit of *integrating the past into recovery*, as the participants shared how they experienced

powerlessness as a factor of their sex addiction. Olivia and Glen revealed their powerlessness by not using safety measures. Olivia explained, "I never used protection. No. You're not thinking… wait, let me protect myself." While Glen explained his reasoning for being tested for infections as, "another opportunity in the past. One of the times my sex addiction was out of control…. I get a complete test in Argentina because they are more advanced."

Howard described the factor of powerlessness in recovery from sex addiction "the idea of powerlessness is very important to integrate initially in one's recovery life. We have no power over this. It is not our fault." Annabelle gave an example of how powerlessness is time consuming to the individual affected by sex addiction. She stated:

> "People say they are going to look it up and then they do not or they will get sidetracked into a porn site, which happens, you know. You take one wrong turn and there you go, seven hours of your day. This addiction is a time suck."

Being vigilant. Merriam-Webster (2013) defined vigilant as alert, watchful, especially to avoid danger. *Being vigilant* evolved as a theme, as the participants shared experiences of their day-today challenges of being alert to avoid addictive behaviors consciously. Olivia, Kevin, and Glen shared awareness as their approach to being vigilant in recovery. Olivia expressed "I'm more aware, cognizant of when I'm acting selfish or I'm not willing or have the willingness – I'm more aware of my feelings." Kevin also incorporated honesty with awareness and described this as: "It's being vigilant and knowing that happy you know, an addict is always an addict." Glen described self-instruction as awareness: "I read a lot of literature on the subject so it keeps me aware of the risks like with myself and the risks that I put myself – I don't want to get that."

Annabelle echoed this self-instruction and described it as “avoiding the pitfalls, well, that is a learning process. So I think it is self-knowledge that is the key for that.”

Being vigilant for Betty and Kim was described through integrating guidelines into their recovery. Betty stated that it “also helps you create boundaries for yourself, boundaries for your family.” Kim explained her personal guidelines: “rules that I come up with myself – to have feelings for the person that I’m going to have sex with instead of just having sex for feeling insecure and to medicate myself.”

Howard, Eva, Clarence, and Leon adapted their behaviors to be vigilant in their recovery. Howard described this adaptation as, “changed outlook again is about working on the character defects. Just – and realizing that I cannot control my life or control any other person.” Eva also echoed the need for work: “You know, you have to actually work at it in all your affairs so that you don’t jeopardize your own sanity and your own peace of mind.” Clarence explained his vigilance as: “I was able to stay in reality and fantasize very little and I think that's one of the keys for a sex and love addict to be in reality, in the moment as much as possible…” Leon described his changed behavior as “actually, the emotional part it’s coming into terms with myself. I am learning – learning to stay in the present.”

Intentional refocusing. *Intentional refocusing* developed as a meaning unit of *being vigilant*, as all the participants refocused their addictive behaviors intentionally on healthy ways to improve recovery. Olivia, Kevin, Howard, Glen, Clarence, and Leon incorporated physical activity into their healthy behaviors. Kevin described his healthy physical behaviors as “practicing good health. You know, exercising which I need to do more and eating healthy.” Howard, Clarence, and Leon included seeking health as part of

their physical activities. Howard spoke of "trying to stay at a healthy weight. Taking my medications, getting regular check-ups, regular exercise." Clarence talked about "going to a gym and working out, which I do. Or going in for regular physical checkups…." Leon explained his physical behaviors as "eating healthy, exercising, checking with your doctor regularly, taking my medications…." Olivia integrated spiritual and emotional activities along with her physical ones, "like volunteer, read literature, pray, meditate, for me it's running because I run."

Betty and Kim described their healthy behaviors as making the right decisions for their health. Betty described her healthy behaviors as "making choices, healthy choices, just doing self-care, self-care and mentally surrounding myself to the right people, the right activities," while Kim solely discussed as safe sex practices "wearing a condom or protection, making sure you're protected."

Living an honest life. *Living an honest life* evolved, as a meaning unit of *being vigilant* as the participants discussed the challenges with being honest with themselves and others in recovery. Olivia described the difficulty of being honest with her husband: "Honesty is a real struggle for me. It's really, really hard for me to open up to him about my addiction." Kevin and Howard discussed honesty from a positive aspect. Kevin revealed that, "I check myself and making sure my motives and the things that I say and I do are not selfish." Howard stated that, "self-loving behavior involves being honest with your behavior."

Annabelle described activities that foster honesty in her recovery: "For me it is going to meetings, being honest and not falling into the pitfalls that trigger me into acting out." Kim expressed her reaction to facing truthfulness in the 12-step group: "Like I

thought I had to be honest in AA but SA was even harder. It was so painful. It was the most painful thing that I have ever had to do."

Giving of oneself. *Giving of oneself* emerged, as a theme when the participants revealed that giving back was essential in developing the good within and was vital to having a successful recovery. Olivia and Betty described giving of oneself in terms of supporting other women affected by sex addiction. Olivia discussed this support as being a part of her recovery: "I'm also working with the steps by giving service, like sponsoring other women." Betty spoke of the personal fulfillment she received from "a lot of women that I sponsor, which helps me because I see myself where I was engaged in the same behaviors." Leon believed in giving of himself to any individual affected by sex addiction: "The biggest feeling from the program has come from my belief that I need to pass my experiences to whoever I can…." Kevin discussed giving of himself to loved ones: "I need to give back. I need to be more present with those that are important in my life."

Informing others. *Informing others* unfolded into a meaning unit of *giving of oneself*, as the participants told their stories of informing others, such as healthcare professionals on sex addiction. Olivia, Eva, and Leon described how their encounters with a mental healthcare provider resulted in the provider gaining a better understanding of sex addiction. Olivia explained this as "I feel like he's learned so much from me about this addiction… but I think with my visits to him, he's really learned more about it." Eva expressed her opinion as, "I went to a lot of therapists and none of them helped me. As a matter of fact, I was helping them. So after a while, we'd be fixing them. I'm like, this is crazy." Leon echoed Eva and described his experience as "I was so, so amazed at how

little knowledge that they actually have even the psychologists and psychiatrists about sex addiction. It's like if you're going to go and see a doctor and the doctor doesn't know about aspirin…."

Informing others from a positive aspect, Kevin explained that he "will use his probation and get very involved in changing the laws. There needs to be a voice." Howard recommended that a person in recovery from sex addiction use "a combined approach, you know, using different modalities where the 12-step program is a main feature of it." Clarence also suggested the 12-step program for recovery and added, "And I say sex therapist, you know a specialist in sex addiction. They're both very useful"

Doing service. According to Hoffman, Wallach, and Sanchez (2010), individuals report a sense of fulfillment and completion in their lives after the community service activity has been completed. *Doing service* evolved as a meaning unit of *giving of oneself,* as the participants revealed how completing community service has been vital to the success of their recovery. Howard explained how being involved with community service affects him. He stated, "I think doing service is perhaps the highest thing a human being can do. It fills up a hole inside of me. Makes me feel meaningful and satisfied and full of grace." Leon described doing service through sponsorship: "It's simply my own experience I am talking to you through my experience, strength, and hope. This is the key thing about sponsorship…." Annabelle explained how she is doing service and of how it has affected her. She revealed, "I am going to start a woman-only SLAA meeting. So yeah, doing the meetings, doing service makes me feel like I am part of something bigger." Table 3 illustrates the meaning units and themes identified for each participant.

Table 3

Meaning Units and Themes

Theme	1	2	3	4	5	6	7	8	9	10
Connecting With Others	x		x				x	x	x	
Reaching Out	x	x			x	x	x	x	x	x
Seeking Shared Understanding	x						x	x		
Connecting With Your Higher Power	x	x		x		x	x	x		x
Managing Stigma	x	x				x	x	x	x	
Revealing Concealing	x		x			x				

(table continues)

Table 3 *(continued)*

Theme	1	2	3	4	5	6	7	8	9	10
Integrating The Past Into Recovery	x	x	x	x	X	x	x	x		x
Reflecting Triggers								x	x	x
Overcoming Powerlessness	x		x	x		x			x	
Being Vigilant	x	x	x	x	X	x	x	x	x	x

Intentional Refocusing	x	x	x	x	x	x	x	x			x
Living An Honest Life	x		x	x					x		x
Giving of Oneself	x	x	x	x				x			
Informing Others	x		x	x	x			x			
Doing Service				x				x	x		

Key: **Bolded Words: Themes**; Non-Bolded Words: Meaning Units; X: Theme/Meaning Unit = Applied to Participant.

General Structure

In the last phase, a general structure was developed, and the "essence of the phenomenon or the essential theme of all its variations," (Giorgi, 1985, p. 93) was described. The researcher formulated a general structure, a narrative description of the phenomenon, based on the analysis of the meaning units that emerged from the individual descriptions. Through the inductive method, the five themes and 10 meaning units, which unfolded from the participants' stories, were synthesized into the general structure that described the phenomenon of health-seeking behaviors of self-identified sex addicts.

The theme *connecting with others* and meaning units *reaching out, seeking shared understanding*, and *connecting with your higher power* represented the overall meaning of belonging. This belonging arose as the participants voiced wanting to be understood, togetherness, unique entities, identifying, and bonding. The majority of the participants expressed one or more elements of belonging and verbalized that this was essential to their recovery and sobriety.

The overall concept of fear evolved from the theme *managing stigma* and the meaning unit *revealing concealing*. This concept of fear indicated how the participants coped with shame, hiding, lying, and judgments while facing their addiction and recovery. The participants shared their challenges of not wanting others to know and the difficulty of talking to others about their addiction or recovery for fear of being stigmatized. Some of the participants expressed the preference for having another addiction instead of sex addiction, as it is such a "hard addiction".

The theme *integrating the past into recovery* and the meaning units *reflecting triggers* and *overcoming powerlessness* signified an overall meaning of seeking relief and survival behavior. As the participants' stories unfolded they used sex as a tool to obtain relief from their history of abuse and abandonment. Sex was also used in an effort to survive, providing protection and preventing actions such as suicide. The participants faced their past of sex addiction to experience recovery.

The theme *being vigilant* and the meaning units *intentional refocusing* and *living an honest life* represented awareness. The participants described awareness as being cognizant, self-caring, knowing boundaries, being honest and reading literature on sex addiction. The participants shared how healthy behaviors in their day-to-day lives were vital to the success of their recovery.

The overall concept of *community* emerged from the synthesis of the theme unit *giving of oneself* and meaning units *informing others* and *doing service*. Community was reflected in the participants' stories through the description of sponsorship, becoming a voice, and passing on experiences to others in the program. The participants also

described experiencing fulfillment, meaningfulness, and feeling important which, enhanced their recovery.

These themes and meaning units were integrated and synthesized into one general structure, which emerged from the participants' descriptions of their stories of seeking health for their sex addiction. These participants sought recovery through the positive aspects of belonging, awareness, and community. They used the negative aspects of seeking relief, survival behavior, and fear to aid in their recovery. The general structure that emerged from the synthesis of the themes and meaning units was:

> "The lived experience of seeking health in recovery from sex addiction—dancing on the outer circle, connected to a community that understands fear, shame, and the struggle to remain vigilant for pitfalls while intentionally refocusing on living an honest life of giving and receiving."

Evaluation Criteria

The participants were viewed as experts of their own experiences, and all verbal accounts were considered true. Therefore, the main criterion for determining the scientific rigor in this study was the correspondence of the identified meaning units and themes pattern with the participants who lived in the phenomenon.

This study applied the standards of trustworthiness in naturalistic research described by Lincoln and Guba (1985) and modified by Beck (1993). Beck (1993) proposed credibility, auditability, and fittingness as three main standards of rigor common to qualitative methods in general rather than to a specific methodology. The following is a description of the criterion and the techniques used to achieve it.

Credibility. Credibility in qualitative research is the criterion by which the truth value of a qualitative study is measured (Beck, 1993). The study had credibility because the researcher studied what was intended to be studied: the health-seeking behaviors of self-identified sex addicts. The descriptions of the stories are true to the experience as told by the participants. Since faithful and vivid descriptions enhance credibility, the researcher kept detailed field notes.

Fittingness. Fittingness is the criterion by which the applicability of the study is evaluated (Beck, 1993). In this study, fittingness was defined as the descriptions of the phenomena studied representing the experiences of a particular group affected by sex addiction and have health-seeking behaviors. Fittingness was also achieved as the interviews were conducted in naturalistic settings and without controlling factors.

Auditability. Auditability is the ability of another researcher to follow the audit trail of a research study (Beck, 1993). The researcher made each step of the study explicit, so that another researcher could follow the audit trail. In phenomenology, the researcher is considered an integral part of the research process, and the audit trail is a record of the research process, and the decisions and choices made by the researcher (Byrne, 2001). Another researcher can follow audit trails used by the researcher in this study and can arrive at the same or comparable conclusion of the study, but not give a contradictory conclusion. In this study, auditability was also achieved as the data collection method, theme emergence, and development were described, and the method of data analysis was delineated. This demonstrates scientific rigor.

Chapter Summary

In this chapter, the men and women who participated in this study were introduced. The descriptive statements of their health-seeking behaviors enabled the researcher to unfold the emerging meaning units and themes. These meaning units and themes were noted throughout the participants' stories, which facilitated saturation. The stories of the participants were documented in a descriptive manner by the researcher. The common meaning units and themes that derived from the stories were:

A Connecting with Others:

1. Reaching Out,
2. Seeking Shared Understanding, and
3. Connecting with Your Higher Power.

B Managing Stigma:

1. Revealing Concealing.

C Integrating the Past for Recovery:

1. Reflecting Triggers, and
2. Overcoming Powerlessness.

D Being Vigilant:

1. Intentional Refocusing, and
2. Living an Honest Life.

E Giving of Oneself:

1. Informing Others, and
2. Doing Service.

The overall structure synthesized from the meaning units and themes was:

> “The lived experience of seeking health in recovery from sex addiction—dancing on the outer circle, connected to a community that understands fear, shame, and the struggle to remain vigilant for pitfalls while intentionally refocusing on living an honest life of giving and receiving.”

The evaluation criteria used in the study were explained. The data, which originated from the dialogues of the participants represented in this chapter provided descriptions of the experiences of seeking health by individuals who self-identified as sex addicts.

Chapter 5:

Summary, Implications, and Recommendations

This chapter presents a summary of the findings of this study. Implications of the findings for nursing practice education, research and policy are offered. The chapter summary includes the conclusion of the story "A Significant Dream" presented in part in Chapter 1.

Summary of Theory, Method, and Findings

Theory. Watson's (1996, 2009) *Transpersonal Human Caring* theory was the grounding for this study. This theory guided the researcher's respectful entry into the participants' worlds, being mindful of the interconnection of mind, body, and spirit.

First the researcher entered each participant's world when they met at a designated site to hold the interview. Second, the researcher perceived the participant's condition of being whole in, mind, body, and spirit. Third, the researcher listened intently and internalized the participant's health-seeking experiences. Fourth, as the researcher listened intently, this allowed openness to occur and the participant to feel comfortable expressing their feelings. Finally, as the participant paused and reflected, he or she was able to describe the efforts in seeking and maintaining health. The interaction between the researcher and the participants was transpersonal as trust and connection occurred.

Method. The phenomenological method was chosen for this study to discover and understand the experience of seeking health for the participants. Phenomenology aims at

gaining a deeper understanding of the nature or meaning of our everyday experiences (Van Manen, 1990). In this phenomenological study, the researcher desired to know more about the phenomena. To understand fully the participants' worlds and experiences, the researcher "must first arrive at it by suspension, or bracketing, of all presumptive constructs about it" (Giorgi, 1985, p.91). By avoiding preconceptions, the researcher relied on what was present phenomenologically to understand fully the experience of the participants. Phenomenology allowed the essence of the phenomenon to be described.

Findings. An analysis of the descriptions of the lived experiences provided by the participants was completed and yielded meaning units and themes. The emergence of these meaning units and themes from the participants expressed feelings of belonging, community, and awareness. Feeling of belonging developed as the participants desired to be understood by other individuals affected by sex addiction; therefore they have a common bond. Community emerged, as the participants described sponsorship and doing service. Feelings of awareness evolved as the participants discussed being attentive and honest about their behaviors in recovery. Negative feelings experienced included fear, survival, and seeking relief. The participants also verbalized feeling fearful, as they faced stigmatization by society while in addiction and recovery. As the participants reflected upon their past addictive behaviors, they became aware that sex was sought for relief and survival as a compensation from a history of abuse and neglect. An analysis of the overall statements and the essences of the participants' experience of the phenomenon seeking health allowed the following meaning units and themes to be developed:

A Connecting with Others:

1. Reaching Out,

2. Seeking Shared Understanding, and

3. Connecting with Your Higher Power.

B Managing Stigma:

1. Revealing Concealing.

C Integrating the Past for Recovery:

1. Reflecting Triggers, and

2. Overcoming Powerlessness.

D Being Vigilant:

1. Intentional Refocusing, and

2. Living an Honest Life.

E Giving of Oneself:

1. Informing Others, and

2. Doing Service.

The overall structure evolved from the meaning units and themes. The resulting synthesis emerged:

> 'the lived experience of seeking health in recovery from sex addiction to dancing on the outer circle, connected to a community that understands fear, shame and the struggle to remain vigilant for pitfalls while intentionally refocusing on living an honest life of giving and receiving."

The findings of this study provided insight to the health-seeking behaviors of individuals who self-identify as sex addicts. The majority of research conducted on sex addiction has been completed in the disciplines of psychiatry, psychology, and biology. As there are few studies in the nursing literature on caring and sex addiction; the findings

of this study will contribute to the discipline of nursing. The findings are discussed with supporting literature and examples from the participants' stories.

Connecting with others. The theme *connecting with others* revealed how being surrounded by others affected by sex addiction was vital to the participants' sustaining recovery. According to Gray, Fitch, Davis and Phillips (1997, being among others with the same struggles brings comfort. This type of connection does not require words, and bonding is immediate and intense. As the participants are aware of this connection with other persons affected by sex addiction, it enhances their commitment to recovery. Clarence said of this theme that, "identifying that also allows me to be part of my group and to feel a common bond with the people who all have the same problem and are trying to recover."

Reaching out. *Reaching out* is a meaning unit of *connecting with others* and refers to the participants' seeking help from healthcare providers while in recovery from sex addiction. Factors, such as prior experience, anonymity, feelings of shame or fear, and awareness of a problem, influenced the participants' utilization of health care services. Although the participants mainly reached out to therapists for care, seeking care from clinics and nurse practitioners was also discussed. As nurses in emergency departments, private offices, and health departments may be the first to encounter a person affected by sex addiction who is reaching out for healthcare, it is essential to understand properly and improve healthcare to these individuals. According to Batten and Dutton (2011), "help-seeking" is a widely used concept applicable to research disciplines in nursing and social work that explore issues, behaviors, and tools related to specific circumstances and population groups. Eva discussed one of the times she reached out as,

> "I went to a mental health nurse practitioner…. So I said do you think you could try lithium? Because lithium's just a mineral. It's not a big deal. She gave it to me. I have never felt bad since then about anything. I was shocked. I thought if I had had this at seventeen, I would've had a completely different life."

Seeking shared understanding. The meaning unit *seeking shared understanding* relates to how the individuals who self-identified as sex addicts voiced being understood by others in their group as vital for recovery. Support and understanding from peers is a key ingredient to the long-term success of individuals in recovery from sex addiction. Participants' meet each other at 12-step groups, such as Sex Addicts Anonymous, and they share their stories of being affected by sex addiction. The benefits of 12-step groups were evaluated in a study by Vederhus, Timko, Kristensen, and Clausen (2011) that revealed that 78% of individuals participate because they find people that will understand them, and 73% participate because they will find others who will guide them to becoming sober. Lopez, Best, Day, and White (2010) credited participation in 12-step groups with remission of the chosen addiction, enhancements in global health, reductions in social and healthcare costs, and reduction in substance abuse mortality. Clarence stated that, "the support group is the spiritual, emotional side, and by emotional I mean bonding with a group, bonding with the members, establishing friendships, mutually supportive healthy friendships in the process of recovery with those people."

Connecting with your higher power. This meaning unit *connecting with your higher power* refers to the participants' needs to have spirituality incorporated in their lives to make a successful recovery. According to Kissman and Maurer (2002), the act of giving up reliance on personal willpower and surrendering control to a collective higher

power promotes spiritual healing and recovery. The participants in the study found their higher power in God, Buddhism, and in themselves.

In the nursing community, it is important to note that the power of faith in promoting health and even curing ailments has attracted increasing attention among healthcare professionals (Kissman & Maurer, 2002). Koening (1998) discussed the health benefits of spirituality as living longer, experiencing less anxiety, coping better with stressful lives, stronger immune systems, and lower blood pressures. Betty expressed the importance of spirituality to her recovery:

> "So just everybody – the people in the program have the best sobriety and the best health of those that use God or a higher power to fill the holes within them instead of a substance, a person, a relationship, or a behavior. So that's number one."

Managing stigma. *Managing stigma* evolved as a meaning unit as the participants discussed how being stigmatized by society has affected their recovery from sex addiction. Being "pointed out," discriminated against, and stigmatized are common experiences of individuals affected by sex addiction. Healthcare professionals, family members, co-workers, friends, and society in general react with fear and rejection once they have the knowledge of the person affected by sex addiction. The stigma of the phrase "sex addiction" causes some people to think of the worst extremes of sexual behavior, despite the fact that any behavior can be subject to loss of control (Herring, 2011). Olivia, expressed how society views persons affected by sex addiction: "There's just such a stigma with it. People hear the word sex addiction and a lot of people think its molesters, child pornography and things like that. It's not really always like that."

For example, individuals affected by obesity are a stigmatized group that experience negative healthcare services and encounters with healthcare professionals. Research indicates that an individual designated obese may avoid or delay healthcare if providers have previously reacted negatively to them based on weight (Drury & Louis, 2002). In the study completed by Merrill and Grassley (2008), *Struggling to fit in* was a common theme in which the participants had a heightened awareness in the office due to unsuitable seating space, size of blood pressure cuffs, and small gowns. These individuals may not seek healthcare.

Scourfield, Roen and McDermott (2008) explained how previous unhelpful experiences, fear of being stigmatized, embarrassment, or shame can inhibit individuals from seeking healthcare services due to fear being stigmatized and not heard by their healthcare provider. They may also experience anger, diminished self-esteem, and complex health issues (Merrill & Grassley, 2008).

Individuals with mental health disorders are another group of individuals that may not seek health services to avoid facing prejudice and discrimination by their healthcare professionals. According to Perese and Perese (2003), people with mental illness receive less in-depth and comprehensive care compared with those without a mental health illness. Common complaints of these individuals include gaps in access to healthcare and incomplete health assessment, screening, and treatment. These individuals struggle to communicate healthcare concerns effectively to their healthcare professional or be heard or acknowledged by them (Tillaart, Kurtz, & Cash, 2009). As a result, these individuals receive inadequate healthcare and have poorer health outcomes.

As healthcare professionals, nurses are in position to recognize and alleviate the negative effects of stigmatization and subsequent health disparities, such as poor healthcare, depression, low self-esteem, and improper diagnosis. Watson's (1996) theory offers a plan of care for nurses to provide care in non-judgmental environment, such as cultivation of sensitivity to oneself and others; development of a helping trusting environment; and promotion and acceptance of the expression of positive and negative feelings.

Revealing/concealing. *Revealing/concealing* is a meaning unit that refers to how the participants in the study described they felt they had to hide and lie about their addiction and/or recovery. Kemp (2009) argues that the relationship between addicts and others are dominated by being untruthful. Individuals who self-identify as sex addicts will lie to themselves and lie and manipulate others to avoid or distort the truth. Participants discussed hiding and lying about their addiction from others, but also protecting others such as family members from their addiction and recovery. Olivia explained, "I have a family and children and I'm trying to protect them. I don't want people knowing what happened to me and still happens to me."

Integrating the past into recovery. *Integrating the past into recovery* is a theme that expresses how the participants looked at their past behaviors to achieve a healthy recovery. Through integrating the past into recovery these individuals are able to make sense of their lives and often make positive decisions that signify commitment and meaning to their recovery choices. Watson (1999) recognizes "the natural human potential and capacity for self-care and self-healing possibilities" (p.16) described in her caring-healing model. Betty reflected on her past: "Almost every… I mean instantly –

men would be around me, but that was such a… it was a pheromone, it was an aura I was projecting. And I don't do that anymore."

Reflecting triggers. *Reflecting triggers* is a meaning unit that refers to how the participants in the study looked back upon the things that initiated their acting out behaviors. The participants described factors such as loneliness, failure, rejection, emotional pain, revenge, and feeling scared. Critical reflection enabled the participants to foster responsible clear thinking decision-making, ultimately transforming their thoughts, knowledge, and understanding (Mezirow, 2000). Betty reflected on her behaviors, as she revealed,

> "So I could be as flirtatious as I want. I could get-and those are, what we call those hits, right, the attraction to some other men. I could get that attention, whatever, as long as I didn't act on it. And after 20 years, and when I look back, well, that is completely inappropriate behavior."

Overcoming powerlessness. *Overcoming powerlessness* is a meaning unit that represents how powerlessness factored into the participants' addictive behaviors. Feelings of worthlessness, powerlessness, and personal failure can induce shame for the person affected by sex addiction (Wilson, 2000). Participants described powerlessness as being out of control, shameful, fearful, and feeling victimized. Betty described overcoming powerlessness as, "Well, I think it's sort of summed up in the first step is my life has become unmanageable and I was powerless over my behaviors." Howard discussed how understanding powerlessness is vital to the person in recovery: "The idea of powerlessness is very important to integrate initially in one's recovery life. We have no power over this. It is not our fault…."

Being vigilant. *Being vigilant* is a meaning unit that expressed the participants' awareness of their behaviors while in recovery. Lack of awareness can be associated with reduced perception of the need to be in recovery, reduced motivation towards recovery, and a greater feeling of being in control over their risky behaviors (Garcia & Garcia, 2008). It is essential that individuals affected by sex addiction be "vigilant" in their recovery to avoid the negative aforementioned issues. Olivia described being vigilant as "I'm more aware of my behaviors because of the program. I'm more aware, cognizant of when I'm acting selfish or I'm not willing or have the willingness-I'm more aware of my feelings."

Intentional refocusing. *Intentional refocusing* is a meaning unit that illuminates how the participants focused on healthy behaviors to avoid their past addictive behaviors. Schroevers, Kraaij, and Garnefski (2008) discussed how positive refocusing and refraining from engaging in rumination or disastrous thinking allows individuals to experience a more enhanced feeling of well-being. Intentional refocusing activities for the participants in this study included meditating, exercising, massages, prayer, and having pedicures. Olivia described her personal intentional refocusing activities as "I always say too in my meetings, like self-care, like it's important to take care of yourself. So for me it's like just getting enough sleep and I work out."

Living an honest life. *Living an honest* life is a meaning unit that relates to how the participants experienced difficulty, but found it necessary to be honest in their recovery. Negative behaviors from their addiction need to be eliminated for recovery to transpire. Full recovery is seen as learning to be honest with self and others. Olivia described her difficulty with honesty as "a real struggle for me. It's really, really hard for

me to open up to him about my addiction." Howard described honesty as from a positive aspect. "Self- loving behavior involves being honest with your behavior. Self- loving behavior involves understanding that we are human and human beings are not perfect. It involves being flexible and not rigid.

Giving of oneself. *Giving of oneself* is a meaning unit that expresses how giving back to others was important to the participants' recovery. Findings from the study by Marcus (1999) on individuals recovering from substance abuse in a therapeutic community revealed that giving back was essential in developing the good within and was essential to living a 'normal life.' The participants voiced giving back to loved ones and to others in the program. Kevin explained this meaning unit as "I need to give back. I need to be more present with those that are important in my life."

Informing others. *Informing others* is a meaning unit that encompasses how the participants told their stories of interactions with healthcare professionals. As the participants desired to be understood, they valued understanding, compassion, being non-judgmental and listening as core qualities needed in a healthcare professional. Olivia described her interaction with a healthcare professional as a learning experience for her psychiatrist: "Well, the psychiatrist is, like I feel like he's learned so much from me about this addiction." There is a paucity of literature regarding the affected population informing healthcare professionals on sex addiction and potential health implications.

Doing service. *Doing service* is a meaning unit that expresses how engaging in service enhances recovery. Sponsoring others affected by sex addiction was a positive influence on the participants' road to recovery. According to Witbrodt, Kaskutus, Bond, and Delucchi (2012), having a sponsor, working the 12 steps, and carrying out service are

associated with higher abstinence rates. Betty discussed doing service in these terms: "And you know, and then I sponsor a lot of women. That too – that a lot of women that I sponsor, which helps me because I see myself where I was engaged in the same behaviors."

Implications

Nursing practice. Nurses are in a position to provide care for individuals affected by sex addiction. Becoming thoroughly acquainted with their health-seeking behaviors and sex addiction will help nurses to intercede and implement meaningful, sensitive care for this population. This study challenges previously held beliefs about being in recovery from sex addiction. Therefore, it is vital for nurses to address their own feelings and attitudes to addiction prior to caring for the affected person, as stigma has been identified as a major barrier to care (Deacon, 2006).

Watson (2002) asserts that if nurses are to provide effective and sustainable care, then it is essential that they have inner strength and be capable of peace, love, and happiness within themselves and with others. Watson's theory provides a guide to achieving nursing's goals of promoting health by bringing balance between body, soul, and spirit to the person. Putting this theory into practice provides nurses with a framework for their clinical decision-making and ensures accountability by increasing clarity of their actions (McCurry, Revell, & Roy, 2010). Understanding the experience of recovery from sex addiction and those seeking health care informs nursing practice and promotes harmony in the nurse-patient relationship.

Nurses could also recognize the problems of concurrent addictions and past abusive relationships (Carter & Dalla, 2006; Charney et al, 2007; Dahlen et al., 2008;

Opitz et al, 2009). Caring for the individual affected by sex addiction can be addressed at the primary, secondary and tertiary levels of nursing care. Primary prevention for the affected population would include the nurse addressing the individual with a history of sexual abuse. An example of secondary prevention would include identifying an individual with frequent screening or acquisition of sexually transmitted infections and understanding their sexual behaviors. Tertiary prevention would include referral to a certified sex addiction therapist or admittance to an inpatient program for individuals affected by sex addiction. Therefore, this study informs the practice of nurses who work in emergency departments, private offices, and health departments.

Education. The best approach to overcome stigma in the healthcare setting is through nursing education (Brackley, 2008). Change in clinical practice areas cannot be accomplished without informed learning, research, and evidence-based practice (Brackley, 2008). In nursing practice settings, informed learning about the experience of sex addiction can be conveyed through in-services that would provide education to staff on the health-seeking behaviors of individuals affected by sex addiction and help identify current problems with their care such as stigmatization. Staff developers could evaluate the current nursing staff, their approaches to the affected population, and the current quality of nursing care provided at the facility. The overall goal of in-service education would be to enhance nurses' attitudes, knowledge, and skills to provide quality care to persons affected with sex addiction.

Nursing school curricula should include sex addiction, abuse, violence, and posttraumatic stress disorder issues. These topics could be covered in the theoretical components of class, and students encouraged to develop skills during practice

encounters. Furthermore, students should be encouraged to examine their own feelings, judgments and stereotypes towards individuals affected with sex addiction. According to Watson (2002), the student should learn how to develop a caring professional relationship with individuals in order to serve society properly.

Nursing research. The participants in this study were Caucasian and Hispanic women and men, and therefore, represented limited ethnic diversity. Future nursing research should be conducted to capture the experiences of self-identified sex addicts from various ethnic groups with a larger sample size. According to Mazzone et al. (2012), recruitment of minorities is especially challenging and can lead to underrepresentation of minorities in research.

Focusing on other populations who have important relationships with individuals affected by sex addiction is also advocated. Interviewing the significant others of individuals affected by sex addiction would provide the opportunity to understand their perspective on their partners' behaviors and on how their influence affects their partners' meaning of care. Nurses need to develop awareness of the impact of sex addiction on family members.

Future nursing research studies should be conducted to explore nurses' knowledge of 12-step groups, such as Sex Addicts Anonymous and Sex Love Addicts Anonymous. As the 12-step group was vital to the health-seeking behaviors of the participants in this study, it is essential that nurses are aware of and understand the essence of these groups to promote adequate care for their patients. Clinicians can play a critical positive role in facilitating their patients' engagement in 12-step groups, but little is known about referral practices or their determinants (Laudet & White, 2005).

Funding for future research studies can be explored through the National Institute on Drug Abuse (Addiction), which is a sub-division of the National Institute of Health. The National Institute on Drug Abuse has not conducted research on sex addiction and is currently funding areas of addiction research such as neurobiology and behavioral therapy. Nurses can advocate for funding for sex addiction research from the National Institute on Drug Abuse as it aligns with a component of their mission statement to support and conduct research across a range of disciplines (National Institute on Drug Abuse, 2012).

Policy. Nurses have the opportunity to influence policy change at the local, state, and national levels to improve the healthcare of individuals affected by sex addiction. At the local level, emergency department nurses can be vital in the development of assessment policies for persons who self-identify as sex addicts. These policies may entail asking for a detailed sexual health history, thorough examination, appropriate screenings, availability of patient handouts, and referrals to 12-step groups and a certified sex addiction therapist. The patient should be cared for in a non-judgmental and compassionate manner, allowing for open communication between the nurse and the patient. Similar policies may be developed by nurses working in the health department or in private office settings. The advanced practice nurse may revise these policies to adapt to their practice and may also incorporate the use of questionnaires with an assessment and having the individual return to the office for follow-up.

Several perspectives exist regarding whether or not sex can be defined and furthermore diagnosed as an addiction (Giugliano, 2008; Hagedorn, 2009; McBride, 2006; Opitz et al, 2009; Zapf et al., 2008). While sexual behavior as an addiction does not

have a formal diagnosis in the *Diagnostic Statistical Manual (DSM*) – IV-Text Revised (TR) American Psychological Association (APA) (2000); it is mentioned briefly in the Sexual Disorder Not Otherwise Specified (NOS) category. This class includes criteria, such as distress about repetitive sexual conquests or other forms of sexual addictive behaviors, and using other individuals as "things" in sexual acts (APA, 2000). As a formal diagnosis for sex addiction does not exist, individuals who self-identify as sex addicts may receive an incorrect medical diagnosis, such as bi-polar disorder, dissociative disorder, or obsessive-compulsive disorder. In addition, without a formal diagnosis, insurance companies may not cover the correct therapy needed for these individuals. As the advanced practice nurse encounters diagnosing, billing, and reimbursement for care in their daily practice, they are positioned to advocate for a recognized diagnosis in the *DSM* and to develop policies to promote care of individuals who have encountered sex addiction. Having a formal diagnosis would reduce the moral stigma associated with sex addiction, much as it has the stigma directed toward persons suffering from alcoholism and drug addiction before these were recognized as legitimate, treatable medical disorders.

Participants' Suggestions

The theme *informing others* emerged from the participants' words and provided a new conceptualization of teaching healthcare professionals to understand and care for the individual affected by sex addiction.

Olivia recommended that healthcare professionals become aware, help, and talk about sex addiction. She expressed that individuals affected by sex addiction do not "reach out" because they do not know of anyone to help them and are "embarrassed" by

their addiction. Betty recommended getting the individual a certified sex addiction therapist and sending them to a meeting in a 12-step group such as Sex Addicts Anonymous. She also encouraged exploring the affected individual's family history. "I think a lot has to do with my family history… family history and family boundaries."

Kevin echoed Betty's recommendations as he encouraged healthcare professionals become familiar with the 12-step groups and not be judgmental while caring for the affected individual. He also recommended helping the affected person to create a structured life. Kevin described this as vital, and recommended

> "Informing them that unaccountable time is dangerous. There needs to be a structure in one's day…. If there is just hours going on where somebody doesn't really have to do anything or answer to anyone, it is a high risk situation."

Clarence suggested finding a therapist and a support group. He stressed the fact that with the nature of the disease, if the person "wants to recover they have to change their life completely. They have to make a clean break with the past, start a new life."

When Howard was asked about his recommendations to healthcare professionals, he said, "I think there is such a huge misunderstanding of sex addiction, yes, the pervasiveness of the addiction. Now it affects so many aspects of your life that it's misdiagnosed." He also recommended that the healthcare professional "be compassionate, be non-judgmental" when caring for one affected by sex addiction. Eva recommended listening to the individual as essential to caring for the individual affected by sex addiction. She also recommended letting the individual open up "think of it as purging their grief and their unhappiness and their digest and their toxicity about everything for the reason that they have shut down in the first place."

Glen recommended that healthcare professionals provide pamphlets and additional information on sex addiction and therapy at their healthcare facilities. The handouts/pamphlets may include information on a "12-step program, a website, can be a referral, can be an online meeting by Skype or a telephone meeting…." Annabelle recommended that healthcare professionals first ask the individual if they are seeking help. Her second recommendation mirrored Glen's on offering handouts and contact information on therapy. Kim suggested providing information on sex addiction and giving the individual a questionnaire. She also recommended directing the affected individual to 12-step groups, such as Sex Addicts Anonymous, and that abused women should be encouraged to attend Sex Love Addicts Anonymous.

Leon recommended that healthcare professionals understand all elements affecting a person's sex addiction, such as childhood trauma, dependency, etc. and that all these areas must be understood fully to provide adequate care. He also recommended that the healthcare professional be non-judgmental: "We get judged enough." By non-judgmental, Leon explained that he meant being understanding and gentle. Being judgmental could impose pain, guilt, and shame: you "don't want to introduce more pain. It doesn't work. It has never worked."

Summary

Nurses are in a unique position to care for individuals affected by sex addiction, as they are often the first individual the person encounters as they seek care from emergency departments, private offices, and health departments. Nurses can help to dissipate the stigma that the affected person may encounter as they enter the healthcare facility. Implications for nursing include opportunities for practice, education, research

and policy. Furthermore, the participants' suggestions for how they would like to be cared for offer personal direction for care and recommendations. The conclusion of the participant's story quoted at the beginning of this dissertation reveals how she viewed herself as being affected by sex addiction.

Significant Dream *(continued)*

> "…there was somebody hiding behind this cardboard cutout. And it was peeking out the window and it was moving and it was trying to say hi. So we went in there and we opened up the door and this older Indian woman, she was Native American. And she was kind of fat, and she was really homely, and she had a bad haircut. Her hair was cut really short and she was sitting there and my friend was just kissing her and kissing her. She looked at me and she goes, get away, get away. I don't like you. She didn't know how to take that kissing. And we go, you don't understand. We've been looking for you. We love you and we missed you so much. And I thought, I love her…. I was so happy. And she was like I'm fine but I was hurt. I'm in here and I'm scared to come out. And then as it changed, that song "I'm Coming Out" by Diana Ross was playing really loud. And I woke up and I couldn't get that song out of my head. There's a new me coming out and I just have to live. And I just got to give. Yeah. But that is how it was. It was like that for me the way that I saw myself in SA as tearing down the wall. And all these face masks that I put on to hide myself."

Appendix A

Institutional Review Board Approval

Institutional Review Board
Mailing Address:
Division of Research
777 Glades Rd., SU-80, Suite 106
Boca Raton, FL 33431
http://www.fau.edu/research/researchint
Tel: 561.297.0777 Fax:561.297.2573
Nancy Aaron Jones, Ph.D., Chair

FLORIDA ATLANTIC
UNIVERSITY

DATE: September 24, 2012

TO: Shirley Gordon, PhD

FROM: Florida Atlantic University IRB

IRBNET ID #: 319550-2

PROTOCOL TITLE: [319550-2] Healthcare Experience of Individuals Who Self-Identify As Sex
Addicts

PROJECT TYPE: *New Project*

ACTION: APPROVED

APPROVAL DATE: September 24, 2012

EXPIRATION DATE: September 23, 2013

REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # B7

Thank you for your submission of Response/Follow-Up materials for this research study. The Florida
Atlantic University IRB has APPROVED your *New Project*. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.
• This study is approved for a maximum of **10** subjects.

• It is important that you use the approved, stamped consent documents or procedures included with
this letter.
• **Please note that any revision to previously approved materials or procedures, including
modifications to numbers of subjects, must be approved by the IRB before it is initiated. Please use
the amendment form to request IRB approval of a proposed revision.
• All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All regulatory and sponsor reporting
requirements should also be followed, if applicable.
• Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.
• Please note that all research records must be retained for a minimum of three years.
• This approval is valid for one year. A Continuing Review form will be required prior to the expiration date if this project will continue beyond one year.
If you have any questions or comments about this correspondence, please contact Elisa Gaucher at:

Institutional Review Board
Research Integrity/Division of Research
Florida Atlantic University
SU-80, Suite 106
Boca Raton, FL 33431
Phone: 561-297-0777
* Please include your protocol number and title in all correspondence with this office.

Appendix B

Consent Form

CONSENT FORM

1)Title of Research Study: *Healthcare Experience of Individuals Who Self-Identify As Sex Addicts*

2) Investigators: *Shirley Gordon, PhD, RN, Professor & Assistant Dean of Graduate Programs* and *Lawren*
Mundy WHNP-BC, MSN, Doctoral Candidate, Christine E. Lynn College of Nursing, Florida Atlantic
University

3) Purpose: The purpose of this study is to understand the health seeking behaviors of individuals
affected by sex addiction.

4) Procedures: If you agree to participate in this study, you will be interviewed by a researcher who will ask
questions regarding your age, ethnicity, relationship status, sexual orientation, and healthcare practices.
You will complete a semi-structured audio taped interview in a private setting convenient to you.
You may be contacted by the researcher within two weeks after the initial interview if necessary to clarify
information and complete the interview. This follow-up visit will also be audio taped.
It is estimated that the session will take 1-1.5 hours each including rest breaks. There will be approximately
five to ten participants in this study over five months. There is no cost for your participation.

5) Risks: The risks involved with participation in this study may include stress, embarrassment, distress, or
sadness when discussing sensitive topics during the interview. You may take a break at any time or stop the
interview if needed. In addition, you may skip a question that you do not wish to answer. If you experience
distress you will be referred to your healthcare provider or nearest healthcare facility. You will be
interviewed in a private setting of your choice to reduce possible risks.

6) Benefits: An anticipated benefit from your participation in this study includes better understanding of sex
addiction and related health seeking behaviors. It is hoped that, in the future the results of this study will help
you and others receive adequate and appropriate healthcare guidance. You will also have the satisfaction of
knowing you have contributed to a better understanding of the sex addict's healthcare needs.
You will receive a compensation of $30.00 in the form of a Visa gift card upon completion of the study.

7) Data Collection & Storage:

All of the results will be kept confidential and secure and only the study investigators will see your data,
unless required by law. Study materials will be stored in a locked cabinet in the lead investigator's office.
Audiotapes and field notes will be destroyed three years after completion of the study.
8) Right to Withdraw: Your agreement to participate in this study is entirely voluntary and you have a right to
withdraw from it at any time without penalty.
9) Contact Information:
*For related problems or questions regarding your rights as a subject, the Division of Research of Florida Atlantic University
can be contacted at (561) 297-0777. For other questions about the study, you should contact the Co-Investigator, Lawren
Mundy, WHNP-BC, MSN, doctoral candidate, at (561) 714-0005.
10) Consent Statement:
*I have read or had read to me the preceding information describing this study. All my questions have been answered to my
satisfaction. I am 18 years of age or older and freely consent to participate. I understand that I am free to withdraw from the
study at any time without penalty. I have received a copy of this consent form.

I agree_____ I do not agree_____ to be audiotaped

Signature of Subject:_____Date_____

Signature of Investigator: _____Date _____

Approved on: 9/24/2012
Expires on: 9/23/2013
Institutional Review Board

Appendix C

Meaning Units, Themes, and Quotes From the Data

Theme: Connecting with Others

Meaning Unit	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
	"I've made some really lifelong friends. That's pretty amazing you know, that's pretty amazing." (page 9, lines 9-10)		"You know, I communicate with my friend, he's my sponsor, my closest friend multiple times a day." (page 3, lines 16-17)		
Reaching Out	"I think reaching out is my best way of describing it. That's what we do in our group. It's the thought of reaching out-in the 12 step group." (page 1, lines 18-19)	"And then I always recommend a certified sex addiction therapist because they get us. So the CSAT will really guide your life. He really saved my life." (page 10, lines 31-33)			"So I said do you think you could try lithium? Because lithium's just a mineral. It's not a big deal. She gave it to me. I have never felt bad since then about anything. I was shocked. I thought if I had had this at seventeen, I would've

					had a completely different life." (page 7, lines 40-42)
Connecting with Your Higher Power	"I think working the steps is really positive. You connect with your higher power." (page 9, lines 12-13)	"I mean the Man upstairs will love me no matter what I do, what I say…" (page 2, lines 18-19)		"…maintaining a conscious contact with a higher power." (page 1, line 16)	

Meaning Unit	Partici-pant 6	Participant 7	Participant 8	Participant 9	Participant 10
		"I just feel that they care about me, that they have my best interest at heart." (page 4, line 29)	"It's a common language." (page 3, line7)	"…just keeping connected to the program and to the movement. I am not by myself; I'm kind of incorporating others into my recovery when I do that." (page 3, lines 29-31)	
Reaching Out	"Yes the therapy helped is	"I also have a psychiatric disorder that I	"So anyway, I have seeing doctors on and	"When I was an intern, I had a lot of	"So I was like I better make an

	something that – when I realize I described myself as sex addict I also break the fantasy – I connect myself more with the feelings…" (page 5, lines 24-25)	see a psychiatrist every four months very briefly just for medication management." (page 2, lines 32-33)	off. But when she sent me to the psychiatrist, when I went to see the psychiatrist actually I got put on antidepressants and on therapy and things got better." (page 10, lines 7-8)	sexual energy, and I did not want to act out, I was trying to release it through Chinese medicine and through acupuncture." (page 6, lines 36-38)	appointment just to be sure that it's not like something really bad. And they were like you tested no for AIDS and you tested negative for this and that but you tested positive for chlamydia. And I was like ah." (page 13, lines 25-29)
Seeking Shared Understan-ding		"…identifying that also allows me to be part of my group and to feel a common bond…" (page 5, lines 31-32)	"…that no addict can provide support – okay no other person can provide the support to an addict like another addict." (page 2, lines 31-32)		
Connec-ting with Your Higher Power	"They said we need to look for our higher power, so that was something that I was not doing for years	"My own -- my individual spirituality takes on a Buddhist form. For me Buddhist meditation is very meaningful	"…basically it is coming into terms with myself and with my higher power actually with the universe. That is who my higher power		"This is God. This is a fun thing. This is how God works when I allow Him to." (page 11, lines

	and now I'm back." (page 10, lines 6-7)	and definitely enhancing. I would say crucial, essential for my sobriety."(page 2, lines 26-28)	is. It is working to better myself emotionally and spiritually. (page 1, lines 14-18)		20-21)

Theme: Managing Stigma

Meaning Unit	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
	"There's just such a stigma with it. People hear the word sex addiction and a lot of people think its molesters, child pornography and things like that. It's not really always like that." (page 16, lines 28-30)	"I just think women are more secretive and more-there's a stigma that a man can be a sex addict, prostitute addict…I don't know why." (page 9, lines 18-20)			
Revealing Concealing	"The whole world is covered up. Like before I was covering up acting out and now I cover up my recovery too. People assume, but I		"I lived a lie. A total lie for once in my life." (page 15, line 24)		

	don’t talk about it and they don’t know that I have a therapist. I live in two very different worlds.” (page 7, lines 15-18)				

Theme: Managing Stigma

Meaning Unit	Participant 6	Participant 7	Participant 8	Participant 9	Participant 10
				“You do not expect that from an intelligent educated woman. You expect that from the Neanderthals with no resources or education, right. That is what society expects. Here I am educated and have a great profession and I am going to get an STD panel because of my behavior. Like I said, she was not overtly – she did not admonish me	

				or anything, she just was very curt and I felt judged" (page 5, lines 30-34)	
Revealing Concealing	"Most of the people ask how much sex is normal; how much is healthy, what is not healthy? So it's a difficult thing for people to understand and to assume also. I don't know. And it's something that they – it leads you to a double life. Something that you hide in your own house, with your partner or your spouse or your sons, or with your children, with your parents, with your				

	relatives and it's something that you hide so much that, you almost believe the lie. So it's difficult to tell the doctor when you hide… something that you cannot assume." (page 14, lines 9-15)				

Theme: Integrating the Past into Recovery

Meaning Unit	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
	"Mine's more like an emotional thing because I usually attach to one person and act out and then another person and act out." (page 14, lines 13-14)	"I mean all those things that when you're in addict mode that you ignore or you have a tendency to ignore at some level." (page 2, lines 8-10)	"And there a lot of…my history of my father was verbally abusive to me and my mother being, I call it emotional incest." (page 6, lines 10-11)	"…the underlying, unresolved issues of one's past that create discomfort, restlessness, stress, fear, and an imbalance in one's emotional life and at a young age, usually, the person has learned to escape and	"My mother left when I was very young. She was horrible. She was just mean and sick. And my mother was an alcoholic, too. Both of them were alcoholics." (page 6, lines 26-27)

				seek relief through sexual, compulsive behaviors." (page 5, lines 14-16)	
Reflecting Triggers					
Overcoming Powerless-ness	"I never used protection. No. You're not thinking…wait let me protect myself." (page 14, lines 19-20)		"So you know, the natural progression of my addiction is a progression, natural. Becoming a natural pattern…was going into that." (page 5, lines 22-23)	"The idea of powerlessness is very important to integrate initially in one's recovery life. We have no power over this. It is not our fault." (page 5, lines 22-23)	

Meaning Unit	Participant 6	Participant 7	Participant 8	Participant 9	Participant 10
	"…we have taken a look at – to my past what took me my life and what took me to be there because sex addiction can be triggered by a lot of things in life." (page	"And I had a brother who was extremely, obsessively homophobic and who abused me emotionally and one time physically pretty badly when he found out	"For the past 10 years, so I kept putting band-aids, band-aids, but still kept acting out." (page 4, lines 13-14)		And so what I did to finally get him off my mind was I went out looking for another guy to replace him. And this was the pattern that I had." (page 4, lines 21-33)

	6, lines 18-19)	that I was gay." (page 4, lines 4-7)			
Reflecting Triggers			"that is one thing that is great in how we have learned to control sex as a tool to manage our emotions. One thing that has been said by the group and I keep hearing and hearing it, that maybe it is this is such a survival behavior. If I didn't have that behavior I really might have died, might have committed suicide, might have done something because it kept me safe."	"I failed my boards and I texted my ex acting out partner that I felt terrible and I needed to feel better. He was a very willing participant…" (page 1, lines 22-24).	"Medicating when I would feel scared or I would feel unlovable or unwanted the attention that I got from men made me feel desirable and made me feel powerful." (page 3, lines 1-2)

			(page 12, lines 23-25)		
Overcoming Powerlessness	"Another opportunity in the past one of the times my sex addiction was out of control… I get a complete test in Argentina because they are more advanced…" (page 8, lines 20-21)			"People say they are going to look it up and then they do not or they will get sidetracked into a porn site, which happens, you know. You take one wrong turn and there you go, seven hours of your day. This addiction is a time suck." (page 9, lines 12-14; 17)	

Theme: Being Vigilant

Meaning Unit	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
	"I'm more aware, cognizant of when I'm acting selfish or I'm not willing or have the willingness- I'm more aware of my feelings." (page 9, lines 16-17)	"…also helps you create boundaries for yourself, boundaries for your family." (page 11, lines 20-21)	"It's being vigilant and knowing that happy you know, an addict is always an addict." (page 3, lines 3-4)	"Changed outlook again is about working on the character defects. Just – and realizing that I cannot control my life or control any other person." (page 2, lines 24-25)	-"You know, you have to actually work at it in all your affairs so that you don't jeopardize your own sanity and your own peace of mind." (page 2, lines 34-35)

Intentional Refocusing	"…those out of circle behaviors are things that are healthy that you should do that are good to do like volunteer, read literature, pray, meditate, for me its running because I run." (page 2, lines 2-4)	"…making the right decisions, choices, making choices, healthy choices, just doing self-care, self-care and mentally surrounding myself to the right people, the right activities…" (page 1, lines 24-25)	"Just practicing good health. You know, exercising which I need to do more and eating healthy." (page 2, lines 29-30)	"Physical trying to stay at a healthy weight. Taking my medications, getting regular check-ups, regular exercise." (page 1, lines 12-13)	"In my recovery, I have studied homeopathy and became a massage therapist which are also very important to me." (page 1, lines 12-13)
Living An Honest Life	"Honesty is a real struggle for me. It's really, really hard for me to open up to him about my addiction." (page 2, lines 26-27)		"You know I check myself and making sure my motives and the things that I say and I do are not selfish." (page 13, lines 10-11)	Self- loving behavior involves being honest with your behavior. Self- loving behavior involves understanding that we are human and human beings are not perfect. It involves being flexible and not rigid." (page 6, lines 1-3)	

Meaning Unit	Participant 6	Participant 7	Participant	Participant 9	Participant 10
	"I read a lot of literature on the subject so it keeps me aware of the risks like with myself and the risks that I put myself – I don't want to get that." (page 5, lines 19-20)	"And I was able to stay in reality and fantasize very little and I think that's one of the keys for a sex and love addict to be in reality, in the moment as much as possible" (page 5, lines 18-19)	"Actually, the emotional part it's coming into terms with myself. I am learning—learning to stay in the present. Addiction robs you from that—behaviors." (page 1, lines 21-22; 25)	"The avoiding the pitfalls, well, that is a learning process. So I think it is self-knowledge that is the key for that." (page 1, lines 10-11, 13)	"Rules that I come up with myself – to have feelings for the person that I'm going to have sex with instead of just having sex for feeling insecure and to medicate myself with is basically what I did is medicate myself with sex." (page 2, lines 20-22)
Intentional Refocusing	"I eat healthy; I do exercise and work out. I try to lower the stress, I take preventive medicine and like check out for everything to – STD's to cancer check-ups…" (page 1, lines 13-14)	"On a physical level I can say going to a gym and working out, which I do. Or going in for regular physical checkups…" (page 2, lines 5-6)	"If it is physical it is eating healthy, exercising, checking with your doctor regularly, taking my medications. Healthy lifestyle." (page 1, lines 13-14)		"…wearing a condom or protection, making sure you're protected." (page 1, line 9)

Living An Honest Life				"Well, for me it is going to meetings, being honest and not falling into the pitfalls that trigger me into acting out." (page 1, lines 4-5)	"Like I thought I had to be honest in AA but SA was even harder. It was so painful. It was the most painful thing that I have ever had to do." (page 6, lines 22-23)

Theme: Giving of Oneself

Meaning Unit	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
	"I'm also working with the steps by giving service, like sponsoring other women." (page 2, lines 19-20)	"…that a lot of women that I sponsor, which helps me because I see myself where I was engaged in the same behaviors." (page 3, lines 4-5)	"That I need to give back, I need to be more present with those that are important in my life." (page 13, lines 16-17)	"I think doing service is perhaps the highest thing a human being can do. It fills up a hole inside of me. Makes me feel meaningful and satisfied and full of grace." (page 3, lines 18-19)	

Informing Others	"…like I feel like he's learned so much from me about this addiction. … but I think with my visits to him, he's really learned more about It. He's talked to my other therapists." (page 10, lines 12-14)		"I plan to use my probation…I plan to get very involved in changing the laws. There needs to be a voice…" (page 24, lines 20-21)	"It has to be a combined approach, you know, using different modalities where the 12 step program is a main feature of it. I don't know why it creates behavioral change the 12 step program, I can't tell you why." (page 9, lines 15-20).	"That's the most… I went to a lot of therapists and none of them helped me. As a matter of fact, I was helping them. So after a while, we'd be fixing them. I'm like this is crazy." (page 10, lines 10-12)
Doing Service				"I think doing service is perhaps the highest thing a human being can do. It fills up a hole inside of me. Makes me feel meaningful and satisfied and full of	

				grace." (page 3, lines 18-19)	

Meaning Unit	Participant 6	Participant 7	Participant 8	Participant 9	Participant 10
			"To me the biggest feeling from the program has come from my belief that I need to pass my experiences to whoever I can…" (page 2, lines 18-19)		
Informing Others			"I was so, so amazed at how little knowledge that they actually have even the psychologists and psychiatrists about sex addiction. It's like if you're going to go and see a doctor and the doctor doesn't know about aspirin...." (page 10, lines 15-18)		

Doing Service			“It’s simply my own experience I am talking to you through my experience, strength, and hope. This is the key thing about sponsorship. Again I am talking to you out of my experience.” (page 3, 21-23)	“In fact, I am going to start a woman only SLAA meeting. So yeah, doing the meetings, doing service makes me feel like I am part of something bigger.” (page 3, lines 22-25)	

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