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Treatment of sexual addiction within the British National Health Service

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Abstract

At present, the prevalence of rates of sexual addiction in the UK is unknown. This study investigated what treatment services were available within British Mental Health Trusts (MHTs) that are currently provided for those who experience compulsive and/or addictive sexual behaviours within the National Health Service (NHS) system. In March and April 2013, a total of 58 letters were sent by email to all Mental Health Trusts in the UK requesting information about (i) sexual addiction services and (ii) past five-year treatment of sexual addiction. The request for information was sent to all MHTs under the Freedom of Information Act (2001). Results showed that 53 of the 58 MHTs (91%) did not provide any service (specialist or otherwise) for treating those with problematic sexual behaviours. Based on the responses provided, only five MHTs reported having had treated sexual addiction as a disorder that took primacy over the past five years. There was also some evidence to suggest that the NHS may potentially treat sexual addiction as a secondary disorder that is intrinsic and/or co-morbid to the initial referral made by the GP. As it stands, treatment for problematic sexual behaviours in Great Britain is often delivered within a private sector. While Foundation Trusts have more flexibility with their funding, implementing specialist treatment for sexual addiction at this point in time is very limited. In implications for treatment in a British context is discussed.

Keywords: Sexual addiction; Compulsive sex; Sexual addiction treatment; National Health Service.

Introduction

As behavioural addictions become more accepted into mainstream British society (e.g., gambling addiction, video game addiction, sexual addiction, work addiction, etc.), it is imperative to have an understanding of the provision of such treatment, and to assess the extent to which the National Health Service (NHS) is accessed by people who believe they are addicted to particular behaviours. One such behavioural addiction is sexual addiction.

Specific types of interventions offered in the UK for sexual addictions have been identified by the *Association for the Treatment of Sex Addiction (ATSAC)* who are a UK-based sexual addiction association (based on the principles of the Certified Sexual Addiction Training in the US) and includes: psychosexual counselling, psychotherapy, cognitive-behavioural therapy, integrative cognitive-behavioural therapy (Stephens, 2011), closed-group therapy (e.g., Hall, 2013), Sex Addicts Anonymous (and similar groups such as Sexaholics Anonymous and Sex and Love Addicts Anonymous), internet-based services (e.g., online cognitive-behavioural therapy), and pharmacotherapy (e.g., anti-depressants).

In Great Britain, there are a number of private and charitable organisations that provide help for those with behavioural addictions such as gambling addiction (Griffiths, 2007). In their study of UK gambling treatment, Rigbye and Griffiths (2011) noted that the rate of treatment seeking by affected individuals for problem gambling remains relatively low compared to other more mainstream addictions (e.g., alcohol, heroin), despite the increased awareness that British people about gambling as an addiction. Such a finding appears to indicate there may be a barrier in accessibility to treatment. This also appears to be the case with sexual addiction. Up until 15 years ago, there was only one (private) treatment service that provided treatment for problematic sexual addiction in Great Britain (i.e., The Marylebone Centre, London). Currently, there is a British-based association for the treatment of sexual addiction (ATSAC) where dedicated professionals and clinicians can be readily accessed through a register. *Relate UK* also offers psychosexual therapy for individuals or couples that are trying to overcome sexual addiction. Such services indicate that

there is a clinical need for sexual addiction treatment although the number of people that require such services is unknown.

Given that sexual addiction and hypersexual disorder are not in either the DSM-V or the ICD-10, it is arguable that they remain generally unacknowledged within the infrastructure of the British NHS. Additionally, sexual addiction and hypersexual disorder do not meet the guidelines proposed by National Institute for Health and Care Excellence (NICE) that provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health reducing inequalities and variance.

To get specific treatment (such as that for sexual addiction) from a mental health practitioner or a specialist service requires a person to be assessed by their local general practitioner, who would, if following the appropriate care pathway, then make a referral if they deemed it necessary. It is likely that the local or regional mental health service would accept a referral for sexual addiction but perhaps treat it as a co-morbid disorder where other negative mood states such as anxiety and depression may take primacy. In such cases, sexual addicts may not have entered the service with their addiction taking primacy. While it may be efficacious to treat secondary symptoms of the addiction, it may result in the addiction itself not being dealt with adequately.

Given these issues and concerns, this study investigated what treatment services were available within British Mental Health Trusts that are currently provided for those who experience compulsive and/or addictive sexual behaviours. This was done in order to gain insight to (i) the incidence rates of sexual addiction, (ii) whether or not sexual addiction is considered as a disorder that is diagnosed within the NHS.

Method

In March and April 2013, a total of 58 letters were sent by email to all Mental Health Trusts (MHTs) in the UK requesting information about sexual addiction and treatment of sexual addictions within their service over the past five years. These requests were made under the Freedom of Information Act (2001) legislation. This is

an act of Parliament in the UK that creates a “public right” of access to information and data (with the application of certain caveats) held by public authorities that are non-personally identifiable. As the NHS underwent major MHT and Service changes in April 2013, only Mental Health Services and those that had reached a Foundation¹ status were contacted. Some of the changes that have taken place recently are that many Mental Health Services remained commissioned by the NHS but have now become social enterprises and/or part of the four-year *Improving Access to Psychological Therapies* (IAPT) program which follows a specific stepped-care model plan approved by the NICE for treating people with depression and anxiety disorders. For example, a patient falling into Step 2 would require a low intensity therapist (to perhaps treat mild depression in primary care) where computerised cognitive behavioural therapy (C-CBT) and a brief psychological intervention that is short-term would be sought. A client at Step 3 would be offered a high intensity intervention as this step deals with a more complex form of depression and anxiety-related disorder. Finally, if Step 3 is not sufficient to help a patient then a referral to Step 4 and/or 5 would be made; this entails the involvement of crisis teams and perhaps even inpatient care depending on the level of deterioration within the patient.

The data request made by the research team was comprehensive and covered aspects of treatment as follows: (i) types of services offering problematic sexual addiction; (ii) number and job title of qualified mental health professionals within each service who offer treatment for sexual addiction, (iii) number of sexual addiction specialists within the MHT; and (iv) lowest age limit for referral. The request information also covered specific referral data for any individuals that had been referred in the past five years for treatment of a sexual addiction problem as follows: (i) number of referrals where sexual addiction was the primary reason for referral; (ii) age of referrals; (iii) gender of referrals; (iv) type of treatment offered; (v) how many clients attended first appointment; (vi) how many clients never attended, (vi) how many clients completed treatment; (vii) how many clients dropped out of treatment

¹ An NHS Foundation Trust is part of the National Health Service in England and has gained a degree of independence from the Department of Health and local NHS strategic health authority.

part way through; and (viii) how many clients were still in treatment (as of April 2013).

The request letter also contained information about the research team and a short justification for the collection of the data. Under the regulations of the Freedom of Information Act (2001), it is a legal requirement that all requests have to be acknowledged within 48 hours, and that responses to the information asked for has to be provided within 20 working days. All the letters sent to the MHTs met the legal time schedules, and where the acknowledgement and response were delayed, satisfactory communication was maintained by the MHT about the delay in requested information.

Results

In total, 53 of the 58 responses to the information requests (91%) were that the MHT in question did not provide a specialist service for treating those with sexual addiction, were not commissioned to do so, and that no referrals were made to the MHT for anyone with a sexual addiction in the past five years. The results were also coded into whether the MHT (i) held and/or collated statistical information on the treatment for sexual addiction, (ii) stated that they did not provide services to treat sexual addiction and were not commissioned by the National Health Service to do so (and by implication do not treat it), and (iii), stated that they both neither collated or held such statistical information on sexual addiction and did provide such services to treat sexual addiction.

Non-collation of statistics on sexual addiction

Four of the 58 Mental Health Trusts (7%) specifically reported that they did not provide services to treat sexual addiction and were not commissioned by the National Health Service to do so. For instance, typical responses included:

“The Trust is unable to respond to your request for information as people who use services are not seen or recorded under such defined or narrow terms”
(South West Yorkshire Partnership).

“The trust does not hold the information you request. Any services of this type are supplied in Bedfordshire by an external organisation” (Bedfordshire and Luton).

A total of 24 Mental Health Trusts (41%) specifically stated that they did not provide services for sexual addiction and were not commissioned by the National Health Service to do so (and by implication do not treat it). For instance:

“I can advise that the Trust does not offer this type of specialist service and we have not had any service users with a primary diagnosis of sexual addiction” (Hertfordshire Partnership)

“The Trust does not provide any specific services for “problematic sexual addiction” and therefore there are no sexual addiction experts employed in our services. We therefore have no specific referral data to share with you” (Sussex Partnership).

“[Our] Trust is a Mental Health and Learning Disabilities Trust and does not provide any kind of sex addiction service” (Northumberland, Tyne and Wear).

“[Our] Trust is not commissioned to provide such a service. Should the Trust need a service like this then we would approach the Commissioners for their views and the Exceptional Treatments Panel that are managed by them” - (Somerset Partnership).

Non-collation of statistics and non-provision of services to treat sexual addiction

A total of 15 Mental Health Trusts (26%) specifically reported that they did not collate statistics on treatment for sexual addiction nor had the provisions to treat it. For instance:

“We can advise you that the Trust does not hold this information as the Trust does not provide this type of service” (Avon and Wiltshire).

“The Trust does not hold information in respect of this element of your request. The Trust does not offer a specialist service” (Oxford Health).

“We do not offer services specifically for sexual addiction and do not employ specialists in this area. Any such referrals received would, therefore, not be categorised in this way; so unfortunately, we do not hold the data you require” (Leicestershire).

Reasons for not treating sexual addiction

Two of the 58 Mental Health Trusts (3.5%) provided specific reasons for not treating sexual addiction. More specifically:

“The Trust does not have any qualified mental health professionals who are qualified to deal with sexual addiction” (Manchester).

This response is slightly different to the ones above as it states a specific reason for not treating sexual addiction (i.e., the MHT does have any clinicians that are qualified to deal with sexual addiction specifically). This response implies that were such specialists available, those with sexual addiction would be treated. The other response noted that although there are practitioners that provide psychosexual treatment services, sexual addiction falls outside of their remit:

“[Our Trust] offers psychosexual services and may treat people who have sexual addictions, however sexual addiction is not covered within the service specification of the psychosexual medicine team therefore referrals with a primary diagnosis of sexual addiction would not currently be accepted by this service” (Leeds and York Partnership).

Treatment of sexual addiction within the National Health Service

Five of the 58 Mental Health Trusts provided information that they had treated sexual addiction within their service. Cheshire and Wirral Partnership NHS Foundation Trust reported that they had a psychosexual team that received *“a small number of referrals for what is labelled as a ‘sexual addiction’ but in reality only a small number of these actually meet the diagnostic criteria.”* This service employed two psychosexual mental health professionals (one medic on a 0.3 contract and one psychotherapist on a 0.8 contract). They also reported that the youngest age of anyone treated for sexual addiction in their service was 18 years old. However, no other detailed information was provided on the basis that it would be too expensive to collate. More specifically, the Trust informed the research team that:

“It is estimated that a manual trawl of 800-1000 files over the past 5 years plus collation of information, at an approximate rate of 5 minutes per file, would cost in the region of £2,080 (for 1000 files). The time and costs for collating this information are well above the maximum time stated in current FOI guidance (18 hours at £25.00 per hour = £450.00). However, as previously mentioned, the number of people with true sexual addictions (i.e.

meet the diagnostic criteria) that are referred are extremely small” (Cheshire and Wirral Partnership)

The Central and North West London NHS Foundation Trust informed the research team that it had set up a pilot to treat behavioural addictions in December 2011 and that the treatment of sexual addiction was part of its remit. However, in August 2012, a decision was taken to *”no longer see people for sex addiction, referring them to other NHS Trusts”* for sex addiction treatment. The Trust also added:

“In addition there is the question about what actually qualifies as sexual addiction. In respect of this whilst no longer seeing people who have problems with sex, we do see people who have problems related to the misuse of pornography. If your definition of sexual addiction includes misuse of pornography then we have [one] clinical psychologist working with this population in our Addictions directorate. The minimum age for referrals to the service is 18 [years]” (Central and North West London).

In relation to all other questions the research team asked, the Trust reported that such data was currently being collated *“for review and future publication”* and that therefore the Trust were withholding this information under Section 22 of the Freedom of Information Act.

The South London and Maudsley NHS Foundation Trust informed the research team that they provided a Psychosexual Service that offered treatment for sexual addiction. The Psychosexual Service comprised one medical Consultant, one counselling psychologist, one clinical psychologist, and two psychosexual counsellors. A total of 23 people (all male bar one female) had been referred to the service for sexual addiction treatment (the youngest of which was 16 years old and the oldest being 64 years. The type of treatment offered included combined medical and psychological treatment (i.e., cognitive-behavioural therapy, psychodynamic therapy, behavioural systems therapy). Of the 23 referrals, 15 turned up for the first appointment and seven never attended (one client had only just been sent an appointment letter). Six people completed their treatment, seven were still in treatment, and two dropped out during treatment.

The Cumbria Partnership NHS Foundation Trust reported that they had one member of staff whose job title is Principal Counselling Psychologist and Psychosexual

Therapist and who dealt with sexual addiction. However, much of the information asked was “not readily available” and that:

“To be able to pull out the required data our psychosexual therapist admin team and IT would have to establish whether it is possible to trace closed caseloads and return details of the amount of caseloads there are. If caseloads are established, admin would need to request integrated files from Clinical Records who would, in turn, need to find and send files by organised transport. The admin team would then need to track files in and notify the psychosexual therapist. The psychosexual therapist would need to read through all entries in every file and record relevant information. Reverse process would include track files out and return files to clinical records where they would have to track files back into their department and file away. The estimated costs are listed below” (Cumbria Partnership)

The Trust estimated that to retrieve the information requested would take 143 hours and would cost £3,575. As this amount was more than the £450 specified in the regulations of the Freedom of Information Act the Trust was “*not obliged*” to respond to the information request.

Finally, the Lancashire Care Foundation Trust reported that they had a number of staff that were qualified to treat sexual addiction including four Psychosexual Therapists (one with an MSc in Psychosexual Therapy and three with a Postgraduate Diploma in Psychosexual Therapy). The lowest age limit for referral to the service was 18 years and in the year prior to the information request they had 17 referrals (aged 19 to 60 years although most – nine clients – were in their 20s) where sexual addiction was the primary disorder requiring treatment. Of the 17 referrals, most (n=15) were male. Seven of the referrals (6 male) attended the first appointment, and seven never attended treatment. To date, three clients (two males) had completed treatment comprising nine sessions. Two clients dropped out of treatment part way through although one of these moved out of the area after five sessions and may have sought help elsewhere after his move. Five clients were still in treatment.

The type of treatment offered for sexual addiction included “*modification of sexual practices, recovering alcohol and substance misuser, self-esteem and unmet emotional needs from childhood plus [childhood sexual abuse] all predisposing, precipitating and maintaining factors plotted and explored.*” Specific psychological

interventions included psychodynamic therapy, and couples therapy. Clients were also treated for other comorbid disorders such as depression and self-harm.

Other treatment agencies that sex addicts would be referred to

Four out of 58 Mental Health Trusts (7%) confirmed that they did not provide specialist services for sexual addiction, but did provide information about other agencies that could be contacted for this information. For instance:

“We are unable to answer your questions as we do not provide any direct services to patients. Please contact Berkshire Healthcare NHS Foundation Trust” (Berkshire).

“I can confirm that NHS Kent and Medway does not hold this information. This information is held by Kent Community Health NHS Trust and Medway NHS Foundation Trust as they deliver sexual health services in Kent and Medway. Please contact them directly to request this information” (Kent and Medway).

Three out of the 58 Mental Health Trusts reported that cases of sexual addiction may have been referred to their service but it did not take primacy (i.e., possible comorbidity with other Axis I and Axis II disorders) or what actions would be taken if such a referral was made. For example:

“We don’t have any services commissioned specifically for this type of service. We may get cases referred where this is a co-morbid issue and probably have someone in the system who has a clinical interest but we do not record as an activity line as it has not been commissioned” (Bradford District).

“The mental health services would not treat a sexual addiction unless it was part of another, diagnosed mental health condition; it may be a form of compulsive behaviour and, if assessed as a problem, it would most likely be treated using CBT. If sexual addiction was the primary problem then a referral would be made to Sheffield Health and Social Care NHS Foundation Trust’s Sexual & Relationship, Sexual Medicine & Transgender Services” (Rotherham Doncaster and South Humber).

“That is not to say that no one with a sexual addiction has been referred, rather it was not their primary reason for referral. Detail regarding ‘secondary’ issues is not recorded at Mersey Care” (Mersey Care).

Discussion

It was clear from the data collected via Freedom of Information requests that the majority of the Mental Health Trusts (MHTs) did not treat and/or acknowledge the existence of sexual addiction. Since sexual addiction is not considered a disorder in the NICE guidelines and is not diagnosed as a disorder in DSM-V and ICD-10, it is perhaps unsurprising that there appears to be little awareness of its conceptualisation, except if occurring with another diagnosable mental health disorder (e.g., where hypersexuality is a symptom of bipolar disorder). However, this study did highlight that the MHTs within the National Health Service view sexual addiction as a specialist service and therefore think that other dedicated services outside of the NHS structure should be treating it. For instance, the response from Hertfordshire Foundation Trust said it did *“not offer this type of specialist service.”* Additionally, two Trusts suggested that they were unable to respond to the request *“as people who use services are not seen under such defined or narrow terms”*. This suggests that sexual addiction appears to be viewed as a narrow term that may not fall under the category of addictions as defined or conceptualized by the MHTs.

Despite the general lack of treatment for sexual addiction, some services (n=5) had treated the disorder and acknowledged it as a clinical reality for some patients. There was also recognition; in particular, by the Central and Northwest London Foundation Trust of pornography addiction, and that they are currently treating a client diagnosed with this disorder. This Trust also set up a pilot group for behavioural addictions that included support and treatment for sexual addiction. However, reasons for why they removed sexual addiction from this cluster were not provided. Two MHTs (South London and Maudsley and Lancashire Care Foundation Trust) provided a breakdown of referrals by gender. Although the numbers were small, they demonstrated that a minority of referrals for sexual addiction are women that are seeking out treatment.

There was also some suggestion from the data collected that sexual addiction may receive treatment via the NHS if co-morbidity with other Axis I and Axis II disorders is present. However, the comorbid disorder may take primacy and leave sexual addiction as a secondary disorder, further increasing its marginalisation within NHS treatment. The findings from this study can be compared to the figures obtained from a similar gambling treatment study conducted by Rigbye and Griffiths (2011) that

also collected data via Freedom of Information requests. They reported that 9% of NHS trusts had treated gambling addiction; this study also found that 9% had treated sexual addiction. Based on the number of requests sent out by Rigbye and Griffiths (327 in the gambling study and 58 in the current study), sexual addiction is treated on a similar scale to gambling addiction yet treatment provisions for both remain relatively low in comparison to other mainstream chemical addictions (e.g. alcohol and cigarette addiction).

It should also be pointed out that sexual addiction (like many other addictions) is a very shame-based disorder that may lead to labelling and perhaps even an element of judgement from therapists who are unfamiliar with its presentation. A hypothetical example is a sexual addict entering a mental health service and describes the occurrence of their intrusive thoughts involving a specific paraphilia, and images such as erotic asphyxiation that may be diagnosed as falling within the 'Not Otherwise Specified' section of the DSM-V (2013) diagnostic criteria of Paraphilic Disorder. A case such as this could be reported as 'risky' under the protocol of NHS by a general CBT therapist. This could entail severe consequences whereby the client is reported to the local authority and/or the police prior to a referral being made to another agency. Therefore, a limited understanding of the disorder may induce more shame (and perhaps even trauma in the most extreme cases) for the client.

As with all studies, there are a number of limitations with the current study. While gathering data under the Freedom of Information Act has arguably proven to be a useful technique, one of the main limitations of adopting this type of approach is that health services and authorities also have the right to charge a fee for dealing with a request. This is often calculated according to fee regulations. However, if prescribed costs are £500 or more then the authority is not obliged to comply with the request. In regards to this study, there were two MHTs that calculated a fee for the number of hours that would be put into filtering out files concerned with sexual addiction. As costs accumulated to more than the specified regulations, this resulted in the MHTs not providing requested information. Non-information may therefore give researchers and other stakeholders within the NHS a somewhat skewed view of whether this specialised area is treated or not. It is also essential to highlight that stereotyping towards addictions as a whole remains, therefore, the misconception of sexual

addiction may have resulted in professionals showing rigid or harsh attitudes towards individuals that suffer from it. This may have also occurred among the MHTs from which the information was gathered.

The use of Freedom of Information requests via electronic mail (email) is an innovative and cost-effective way of collecting data to gain insight into a marginalised disorder such as sexual addiction in the UK. Not only is there evidence of an email being sent, but it is also less time-consuming. Traditional methods such as letters sent by 'snail mail' may get lost in transition, and secondly, an acknowledgment within 48 hours can be a small window for MHTs if responding through a postal letter. An information request via email also provides leniency for the MHT to ask for additional information that may be required in order to process the request efficiently.

The findings from this study also provide some foundation on which future research into sexual addiction can be built upon. For example, determining a general prevalence rate of the disorder within the UK, that is defined as non-paraphilic (i.e., making it distinct from paraphilic-related disorder). This would help inform treatment interventions in the near future. Additionally, the terms sexual addiction and/or hypersexual disorder may be better understood by breaking it down into its subtypes (e.g., masturbation, pornography, cybersex, telephone sex, strip clubs, etc) by other clinicians. While there is overlap that can potentially lead to confusion among mental health professionals, it also needs to be understood that irrespective of its subtypes, an individual who is sexually addicted does not imply that there is the existence of multiple affairs with other parties involved, and that such acts can be carried out alone and/or online.

It is also worth mentioning that sexual addiction can be opportunity-induced, with reference to the availability of sexual information through various media that can be accessed by many adolescents. For example, Hall (2013) has illustrated that the profile of a typical sexual addict is changing. In her survey 2012 survey of 350 individuals, 44% reported no history of sexual abuse or trauma, and 26.5% reported never having an attachment-related issue (Hall, 2012). While these results lack empirical grounding, the findings from this survey shed light to the diversity in the onset and maintenance of related sexual activities that can potentially be escalated

on the internet. Where a rapist may act out his frustration via opportunity, a sex addict may engage in compulsive masturbation and/or 'cruise' on the internet as a means of coping to compensate for the lacking of types of sex they may be involved or in fact having the internet as an additional medium to make sense of and/or act out their intrusive urges and fantasies without the presence of shame. Such activities may lead to online behaviours being transferred to offline situations, thus creating substantial levels of risk. This further perpetuates the cycle of addiction and its consequences. It is therefore fundamental for clinicians to thoroughly explore current behaviours and risk using models such as the triple 'A' engine (accessibility; affordability and availability; Cooper, 1998) before delving deep into the historical factors and familial aspects of the patients.

To the authors' knowledge, this study is the first of its kind to investigate the treatment provision for sexual addiction within the National Health Service in the UK. It identified that sexual addiction is not generally on the public health agenda within the UK and/or on the radar of those with responsibility for NHS commissioning services. This could be in part due to the proposed DSM-V criteria (for Hypersexual Disorder) not being included in the latest edition of the DSM (APA, 2013) and the fact it is a shame-based disorder that is not discussed and/or experienced by the vast majority of the British population. Practitioners and the general public alike may simply not view sexual addiction as an issue for professional help, and even if they did, such help may not be sought.

In addition to the above, sexual addiction may not be as straightforward to diagnose among those who have little or no understanding of the concept. Since the shift to a digitalised society, sexually explicit material such as pornography and online chat rooms are freely available; the delivery of a stringent psycho-education session in the initial stage to those entering treatment can potentially minimise harm and risk posed to self and/or others. As it stands, awareness of the addictive properties and the range of risks may be involved with such behaviours is still minimal, therefore, a supplementary branch to sexual health and even mental health services reiterating the risks of the addiction for the younger generation should be considered.

The implications of this study could be far reaching. Despite readily obtainable information concerning risky sexual behaviours (with specific references to sexually transmitted infections), it seems as though information provided to the British population regarding sexual addiction to some degree contradicts the types of treatment-related services that are offered by the NHS. For example, on the *NHS Choices*² website sexual addiction and even love addiction is advertised and acknowledged as a clinical reality that can have severe consequences along with a short video of a real-life example of a female love addict. Suggestions on the website for treatment are CBT for addictions and for an individual to join a self-help group (e.g., SLAA). However, as suggested by Hall (2013) many of these groups are facilitated by volunteers where professional therapeutic input is lacking. Such support groups are often more effective when individual therapy is running simultaneously.

Given the general increase in internet use, sexual addiction (and some of its subtypes such as cybersex and pornography addiction) is likely to become an area requiring specialist treatment interventions in the future. This is in part due to the increased accessibility and affordability and anonymity of the Internet to which the younger generation are born in (e.g., Cooper, 1998; Orzack, Voluse, Wolf & Hennen, 2006). With this in mind, some implications for treatment that can be built upon are proposed.

The present study ascertained that many NHS Mental Health Trusts are not commissioned to treat sexual addiction at this present moment in time (apart from the few Foundation Trusts that have treated sexual addiction as a primary disorder). Nevertheless, a time-limited psycho-educational model could be introduced to all MHTs that treat depression and anxiety-related disorders.

Although there is a small minority of NHS Mental Health Trusts that provide treatment for sexual addiction, this study highlighted there is still a long way to go before there is provision of localised, problem specific treatment to sex addicts within

² NHS Choices: <http://www.nhs.uk/Livewell/addiction/Pages/sexandloveaddiction.aspx>

the British NHS system. It is more difficult to cater for treatment in this area as a prevalence rate of the disorder is still currently unknown. Despite this, it is evident that there is a clinical reality of the disorder that is present among both males and females.

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