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Sexual addiction and paraphilias

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Introduction

How we understand the role that paraphilias play in the context of so-called sexual addiction depends on our understanding of both paraphilias and the concept of sexual addiction. It is important to note that when the term 'sexual addiction' is used, it almost always refers to a physical – that is an observable – behaviour. The same can be said for all the other terms that have been used to describe the phenomenon, such as 'hypersexual behaviour' or 'compulsive sexual behaviour'. In contrast, the term 'paraphilia' does not tell us anything about an individual's sexual behaviour per se. In fact, every specified diagnosis of a 'paraphilic disorder' can be assigned to an individual without knowing or stating anything about that individual's sexual behaviour. The notion that we may differentiate paraphilic from nonparaphilic sexual addictions implies a distinct category of behaviours, with the main issue being the addiction to sexual behaviour, and the presence of a paraphilia merely influencing the descriptive characteristics of the sexual behaviour. While applying the concept of addiction to sexual behaviour raises its own questions, which are addressed in other chapters of this book in more detail, the focus in this chapter is on understanding paraphilias within a broader concept of sexuality.

In this chapter we demonstrate that, while paraphilic behaviour can resemble so-called paraphilic sexual addiction, it is clearly about something fundamentally different. We take a close look at paraphilias and paraphilic disorders, and we explore the difference between a sexual interest and a sexual preference. Finally, we introduce a model of sexual preference that enhances our understanding of how paraphilic behaviour differs from so-called addictive sexual behaviour.

The evolution of the term 'paraphilia'

The term paraphilia was coined in 1903 by the Austrian sexologist Friedrich Salomon Krauss (Krauss, 1903), who suggested to fellow sexologist Iwan Bloch that the term was a 'non-judgemental alternative to the twin phrases psychopathia sexualis and sexual perversion' (Janssen, 2014: 1245). The term is pieced together from the Greek words *para* and *philia*. The prefix 'para' means 'along side of, aside from, subsidiary to' (Birchard, 2011: 161, quoting Coleman, 1995: 335) but is also used to designate 'activities auxiliary to or derivative of that

denoted by the base word [...], and hence abnormal or defective' (Dictionary.com, 2016a). 'Philia' comes from philos, meaning dear, beloved or 'loving' (Dictionary.com, 2016b). The term paraphilia, therefore, 'correctly emphasizes that the deviation (para) is in that to which the individual is attracted (philia)' (American Psychiatric Association, 1980: 267), and 'may be most accurately rendered as meaning *love for other/marginal objects*' (Downing, 2015: 1139). As Janssen notes:

> It pays to meditate for a moment on the seeming intrigue that the word, deploying Greek against Greco-Latin, should have been coined in a medical context, but only by an ethnographer addressing his anthropologically inclined sexologist colleague to watch his medical language – furthermore in an admonition to medical men to adopt a more anthropological, and less medicalizing, perspective on the vita sexualis.
>
> *(Janssen, 2014: 1245)*

The American Psychiatric Association introduced the term 'paraphilia' in 1980 in its third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The term was intended to replace the expression 'sexual deviation', which had been used in DSM-II (American Psychiatric Association, 1968), with a less stigmatising term, while still describing a psychopathology, that is, a mental disorder. De Block and Adriaens (2013) describe in detail how earlier and subsequent editions of the DSM differed in terms of terminology and diagnostic criteria in this category. They provide an excellent 'historical perspective on how both American and European psychiatrists have conceptualized and categorized sexual deviance throughout the past 150 years' (De Block & Adriaens, 2013: 276).

Since DSM-III (American Psychiatric Association, 1980), and up until very recently, the term paraphilia was used internationally as a label for an allegedly diagnosable psychiatric disorder involving sexual experience and behaviour of a certain kind. In DSM-III, the understanding of the essential feature of these disorders was that the 'unusual or bizarre imagery or acts are necessary for sexual excitement' and that they 'tend to be insistently and involuntarily repetitive' (American Psychiatric Association, 1980: 266). Paraphilias were described as 'a repeatedly preferred or exclusive method of achieving sexual excitement' (American Psychiatric Association, 1980: 268). This understanding of paraphilias, namely as something involuntarily repetitive and as a 'preference', is much closer to the clinical reality and in sharp contrast to the modern way of referring to paraphilias as simply being 'interests'.

Since DSM-IV-TR (American Psychiatric Association, 2000), the term paraphilia has essentially referred to an ongoing period of at least six months of recurrent, intense and problem-causing sexual fantasies, urges or behaviours, which are considered to be atypical. Among those specified were fantasies, urges or behaviours involving prepubescent children (paedophilia), those involving non-consenting victims (voyeurism, exhibitionism, frotteurism and sexual sadism) and those not involving non-consenting victims (sexual masochism, fetishism and transvestic fetishism; First, 2014).

Defining the above: voyeurism refers to observing an unsuspecting person who is naked, in the process of disrobing or engaging in sexual activity; exhibitionism involves exposure of an individual's genitals to an unsuspecting person; frotteurism refers to touching and rubbing against an unsuspecting person; sexual sadism involves enacting real (not simulated) acts in which psychological or physical suffering, including humiliation, is inflicted on a person; sexual masochism refers to engaging in real (not simulated) acts of being humiliated, beaten, bound or otherwise made to suffer; fetishism involves the use of non-living objects, for example shoes and female undergarments; transvestic fetishism refers to cross-dressing.

In order to fulfil the criteria for diagnosis under DSM-IV-TR, these recurrent and intense non-normative sexual experiences and/or behaviours (referred to as Criterion A) had to cause distress or impairment in an important area of functioning (referred to as Criterion B). In cases when there was potential harm to self or others (children or non-consenting adults), acting out the sexual behaviour was sufficient by itself to meet Criterion B.

From a purely sexological (that is, non-medical) perspective this definition posed a problem. It left no room to describe (in a non-pathologising way) the sexuality of people who had these sexual fantasies and/or engaged in respective sexual activities in the specified manner (Criterion A) but neither experienced distress, nor impairment, nor caused harm to themselves or others (Criterion B). This group has been referred to as being comprised of individuals with a 'sexual attraction pattern' (SAP) involving, for example, watching, showing, touching, fetish or children (Ahlers et al., 2004b). More recently, these non-normative fantasies and behaviours have been referred to as 'paraphilia associated sexual arousal patterns' (PASAPs; Ahlers et al., 2011), making it possible to refer to a person as showing, for example, a masochistic PASAP. The usefulness of being able to differentiate the two groups by assigning different terms is apparent when considering the different levels of prevalence that have been reported on the two phenomena (Ahlers et al., 2011; Dombert et al., 2016). In one community sample (Ahlers et al., 2011), 9.5 per cent of the 367 male participants reported a paedophilic PASAP but only 3.8 per cent reported having acted upon their respective sexual urges, arguably presenting a paraphilia as defined in DSM-IV-TR, in this case paedophilia. In a representative internet-based study (Dombert et al., 2016), 4.1 per cent of the 8,718 male participants reported sexual fantasies involving children but the estimated prevalence of paedophilia as defined in DSM-IV-TR was less than 0.1 per cent for the exclusive type and less than 0.6 per cent for the non-exclusive type ('exclusive type' being defined as a sexual preference exclusively for prepubescent children and 'non-exclusive type' being defined as a sexual preference for prepubescent children as well as for adults and/or pubescent children). There are some limitations to the comparability of the two studies. However, the results confirm that, while some people have recurrent, intense sexually arousing fantasies involving children, they are neither distressed nor impaired by these fantasies, nor do they act upon the respective urges. Referring to these individuals by using labels such as the DSM-IV-TR diagnostic term paedophilia does not merely constitute a misdiagnosis or diagnostic error, it is diagnostic malpractice.

With the publication of DSM-5 (American Psychiatric Association, 2013), the term 'paraphilia' has been replaced with the term 'paraphilic disorder', as a label for a mental disorder. Paraphilias are now to be understood as nothing more than 'intense and persistent atypical sexual interests' (Pullman et al., 2016: 483), in other words, non-disorders. In this chapter we use the term paraphilia in accordance with this description, namely to refer to what was described above as a PASAP, that is a non-pathological, so-called atypical sexual preference. Thus, paraphilia now merely refers to having sexual fantasies and/or engaging in sexual behaviours of a certain kind. The term 'denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners' (American Psychiatric Association, 2013: 685). The manual further specifies that, in some circumstances, 'the term *paraphilia* may be defined as any sexual interest greater than or equal to normophilic sexual interests' (American Psychiatric Association, 2013: 685). In addition, it states that 'there are also specific paraphilias that are generally better described as *preferential* sexual interests than as intense sexual interests' (American Psychiatric Association, 2013: 685).

It should be noted that using the term 'sexual interest' in this context obscures the fact that we are dealing with an integral and essential component of personality. We do not speak of an 'intellectual interest' when referring to an individual's intellectual capability; instead, we speak of

intelligence and rightly understand it as an integral and essential component of personality that is rather stable by the age 20. A person's intellectual interest might include collecting stamps or coins, and the interest can change several times during his or her lifetime. That person's intelligence, however, will not change in any relevant way. A person's sexual interest might include watching erotic movies, and it also can vary over time. That person's sexual preference as a part of their personality will persist in general over the lifetime. In the context of sexuality, the meaning of the term 'preference' exceeds that of everyday language, such as in preferring Thai over Italian cuisine, or rugby over tennis. It describes a rather stable part of an individual's personality comparable to intelligence.

The current DSM clearly states that 'a paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not automatically justify or require clinical intervention' (American Psychiatric Association, 2013: 686). It is important to note that the basic structure of the diagnostic criteria has not been changed. Criterion A and Criterion B have remained the same and both still have to be met to justify a diagnosis of a mental disorder. This has been the case since DSM-III-R (American Psychiatric Association, 1987), with the exception of DSM-IV (American Psychiatric Association, 1994) in which distress or impairment was a prerequisite for a diagnosis of all specified disorders – including those with forensic relevance – and could not be substituted with having acted on the respective urges. It is certainly a step in the right direction to reduce the stigma towards people who have so-called non-normative sexual fantasies and neither experience distress nor cause harm.

Various authors have questioned the usefulness of using the term paraphilia in this new way as it has served as a diagnostic label for a mental disorder for more than the past three decades (Briken, 2015; Fedoroff, 2011; First, 2014; Moser, 2010). The rationale for describing a non-pathological human experience, such as being sexually aroused by cross-dressing, with exactly the same term that has been used as a diagnosis for psychopathology for more than 30 years seems rather elusive. More generally speaking, as Briken (2015) noted, what justifies the listing of something non-pathological such as the DSM-5 paraphilias in a diagnostic manual for mental disorders in the first place?

When therapists assign the DSM-diagnosis of a paraphilic disorder to a person, they are essentially diagnosing that individual as being mentally ill. Such a diagnosis might have serious implications in a forensic context. It is, therefore, important to thoroughly re-evaluate the DSM-5 recommendations for cases involving non-disclosing individuals. Here, the variable 'victim count' becomes crucial as, according to the DSM-5, it may determine if Criterion A is met; for instance, in the case of voyeuristic disorder, the manual states that recurrence 'may, as a general rule, be interpreted as three or more victims on separate occasions. Fewer victims can be interpreted as satisfying this criterion if there were multiple occasions of watching the same victim [...]' (American Psychiatric Association, 2013: 687). The DSM-5 suggests similar conditions for exhibitionistic disorder, frotteuristic disorder and sexual sadism disorder (but not for paedophilic disorder). The victim count variable's credibility is even emphasised in the DSM-5: 'Note that multiple victims [...] are a sufficient [...] condition for diagnosis' (American Psychiatric Association, 2013: 687). The possibility that a person can be diagnosed as being mentally ill based solely on their behaviour affecting three victims, or fewer in some cases, is problematic.

The future will show if and how the American Psychiatric Association will meet this depathologising challenge, as well as address other justified criticism (Briken, 2015; First, 2014). In this context, therapists especially ought to keep in mind the various factors that may influence the American Psychiatric Association's decision to use or drop a label, or to include or no longer include a diagnostic category in the DSM. The chair of the DSM-III task force, Robert L. Spitzer, stated in 1974 (immediately after homosexuality was deleted from the DSM) that one reason why he had not given much thought to deleting other 'sexual deviations' (as they were then called) from the DSM was perhaps that 'the voyeurs and the fetishists have not yet

organised themselves and forced us to do that' (quoted in De Block & Adriaens, 2013: 289). Spitzer stood by this hint to lobbyism more than 30 years later ('you have to have a lobby, [...] you have to have troops' [quoted in De Block & Adriaens, 2013: 289]) and 'argued that, among other reasons, the paraphilias cannot be removed from the DSM "because it would be a public relations disaster for psychiatry"' (quoted in De Block & Adriaens, 2013: 289). Or, in Money's words, the paraphilias are listed 'because of their forensic history, rather than their pathology and therapeutic need' (Money, 1984: 164).

The terms 'sexual addiction' and 'paraphilia' carry with them a negative pathologising connotation and, in continuing to use them, we might be doing more of a disservice than we would like to believe. The assertion that particular sexual fantasies are atypical, unusual or non-normative is also questionable (Ahlers et al., 2011; Joyal, 2015; Joyal et al., 2015; Joyal & Carpentier, 2016; Långström & Seto, 2006), as is the assertion that engaging in specific sexual behaviours indicates psychopathology (Wismeijer & van Assen, 2013). In an internet survey, Joyal and his colleagues (Joyal et al., 2015) asked 717 female and 799 male adults to rank 55 sexual fantasies using an extended version of the Wilson's Sex Fantasy Questionnaire. They found that only two fantasies were statistically rare (2.3 per cent or less) for women or men, nine were unusual (15.9 per cent or less), thirty were common (more than 50 per cent) for one or both genders, and five were typical (more than 84.1 per cent of the sample). Wismeijer and van Assen (2013) concluded that 'BDSM (bondage and discipline, dominance and submission, sadism and masochism) may be thought of as a recreational leisure, rather than the expression of psychopathological processes' (Wismeijer & van Assen, 2013: 1943). In another online survey (Spenhoff et al., 2013), personal distress and functional impairment in self-identified 'sex addicts' were investigated using a questionnaire that included 20 items of the German version of the Sexual Addiction Screening Test-Revised (SAST-R). Of the 349 male participants, approximately one quarter (N=83) claimed not to be distressed by their sexual behaviour. However, of these 83 individuals 49 scored above the SAST-R core scale cut-off, indicating they were 'sex addicts'. We may rest assured that a questionnaire score is understood by most researchers and therapists to be no more than a score, and by all means not a substitute for a diagnosis following a clinical interview. Still, if 14 per cent of a sample are potentially pathologised, presumably for no reason other than engaging in a particular behaviour, then caution must be exercised with respect to the instruments we choose to administer.

Sexual preference

In the World Health Organization's (WHO) current edition of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10), the corresponding term for the DSM term 'paraphilic disorder' is 'sexual preference disorder' (WHO, 1992). The respective category, 'F65: Disorders of sexual preference', is a sub-category of F60–F69, 'Disorders of adult personality and behaviour'. F65 only lists fetishism, fetishistic transvestism, exhibitionism, voyeurism, paedophilia and sadomasochism as specified disorders. Frotteurism falls into a residual category of 'Other disorders of sexual preference'. In contrast to DSM, the ICD-10 mentions neither distress nor impairment as necessary criteria for diagnosis, and does not differentiate between fantasies, urges and behaviour.

With respect to connotation, the ICD-10 terminology seems more suitable for differentiating between the two groups (people with a paraphilia and people with a paraphilic disorder), in that it offers the neutral, unbelted term of 'sexual preference' as a base expression.

The notion of sexual preference could prove helpful in overcoming the judgemental and potentially stigmatising way of referring to people engaging in problem-causing sexual

behaviour (PCSB). PCSB is defined as continuing to engage in sexual activity despite negative consequences and resulting in personal distress due to a perceived lack of control over the sexual behaviour. The term PCSB has been suggested by the authors of this chapter as an alternative to the controversial terms used so far, such as 'sexual addiction', when referring to this phenomenon. The term PCSB captures the essential consequence of the phenomenon without disrespecting or offending people who are directly affected by it. It is a purely descriptive and, thus, in our opinion, the more rational term (see Section 3.1 in this book for further details).

The following description of the documentation guide *SEXPSYCH-5x3* (Ahlers et al., 2004a, 2008) demonstrates how sexual preference fits into a broader concept of sexuality. The *SEXPSYCH-5x3* is an instrument that was developed to optimise the academic and professional training of physicians and psychologists in sex therapy. It provides an overview and explains the overarching, non-clinical aspects, or fundamentals, of sexual experience and behaviour in a compact and structured manner. As such, this overview serves as a guide. Its focus on clinically non-relevant aspects of sexuality helps the therapist or researcher to maintain a wider focus when collecting information. The instrument's name refers to its five specified components, each of which has three categories:

1. *Three pillars of sexual experience and behaviour*: if we understand human sexuality as a bio-psychosocial phenomenon, sexual experience and behaviour are based on three intertwining pillars: a biological (physicality), a psychological (personality) and a sociological (societal dependence) or social (partner relatedness) pillar.
2. *Three dimensions of sexual experience and behaviour*: reproduction, lust and relationship were identified as three central dimensions of sexual experience and behaviour. The term 'dimension' reflects the importance of their meaning for a person, similar to other dimensions of personality. The three dimensions refer to the significance of sexuality for procreation, for attaining pleasurable sensations and sexual arousal, and for fulfilling basic psychosocial needs, such as the need for relationship, acceptance, appreciation, emotional security, closeness or sense of belonging. In other words, the dimensions refer to different functions of sexuality (reproduction, arousal and communication). Thus, sexual experience and behaviour is fundamentally determined by respective motives. The relevance of these dimensions may differ between individuals, as well as within an individual over the course of time.
3. *Three axes of sexual preference*: sexual preference is composed of (a) our *sexual orientation* towards the preferred sex of the desired sexual partner (on a continuum from 100 per cent heterosexual to 100 per cent homosexual), (b) our *sexual alignment* towards the preferred stage of physical development of the sexual partner's body (child, adolescent or adult), and (c) our *sexual inclination* towards (i) a preferred specific *type* of sexual partner and (ii) a preferred specific *mode* of sexual activity (see Figure 2.4.1).
4. *Three realms of sexual experience and behaviour*: our sexual preference can manifest itself in (a) the realm of experiencing specific sexual thoughts, fantasies and dreams, in (b) the realm of sexual behaviour in terms of physically realised specific sexual activities, and in (c) the realm of our sexual self-concept, that is how we define ourselves as a sexual being or in a sexual respect. Note that a specific sexual activity is not automatically indicative of that person's sexual preference. For example, same-sex sexual activity in a prison setting is not necessarily an indication of a sexual orientation towards same-sex, and having sexually abused a child is not necessarily an indication of paedophilia.
5. *Three forms of sexual behaviour*: the realm of sexual behaviour can consist of three different forms of sexual activity. The first is auto-erotic activities, consisting of sexual self-stimulation and masturbation. The second is a socio-sexual form of extra-genital interaction, such as cuddling, caressing and kissing, and the third is a socio-sexual form of manual, oral or other genital stimulation, such as petting or penetrative sex.

(Ahlers et al., 2004a/2008)

When assessing the role that an individual's sexuality plays in their PCSB, the most relevant component to consider is sexual preference. To be more precise, the focus should be on their sexual inclination towards a preferred specific *type* of sexual partner and a preferred specific *mode* of sexual activity (3c-i and 3c-ii). The most reliable source of information about an individual's sexual preference is found in the realm of fantasy (4a). If we regard our sexual fantasies as mental movies that are written and directed only by our preference and basically spared from censorship, for assessment purposes we would fast forward to the scene that plays immediately before orgasm.

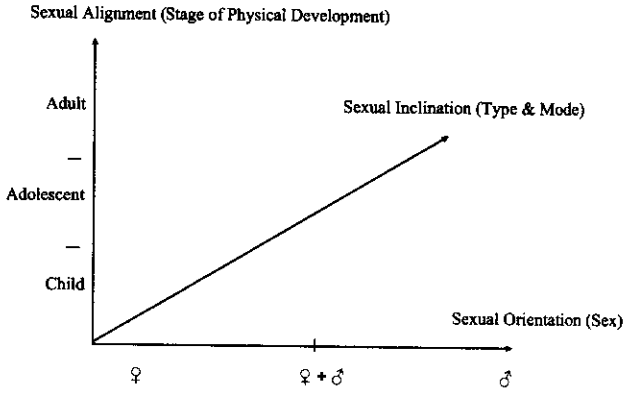

Figure 2.4.1 The Three-Axes-Model of Sexual Preference

The so-called third axis of sexual preference, the sexual inclination towards a preferred specific *type* of sexual partner and a preferred specific *mode* of sexual activity, resembles the current definition of paraphilias in the DSM-5 (if 'activities' are understood as fantasised activities, and 'interests' are understood as being preferences, and not as a synonym for behaviour):

> Some paraphilias primarily concern the individual's erotic activities, and others primarily concern the individual's erotic targets. Examples of the former would include intense and persistent interests in spanking, whipping, cutting, binding, or strangulating another person, or an interest in these activities that equals or exceeds the individual's interest in copulation or equivalent interaction with another person. Examples of the latter would include intense or preferential sexual interest in children, corpses or amputees (as a class), as well as intense or preferential interest in non-human animals, such as horses or dogs, or in inanimate objects, such as shoes or articles made of rubber.
>
> *(American Psychiatric Association, 2013: 685)*

The key feature of paraphilias is that the specified imagery or acts tend to be insistently and involuntarily repetitive and repeatedly preferred for sexual excitement (American Psychiatric Association, 1980). They can be so crucial that they become the exclusive method of achieving

sexual excitement. Paraphilic behaviour, then, is about acting according to a sexual preference in order to achieve or intensify sexual arousal. Acting against a sexual preference is not likely to result in achieving sexual arousal. The important distinction, then, is the question that guides a person engaging in paraphilic behaviour is 'what must I do to achieve sexual excitement?', whereas the question that guides a person engaging in PCSB is 'what could I do to feel better quickly?'

In this conceptualisation ('The Three-Axes-Model of Sexual Preference', Ahlers, 2010), sexual preference (i) is understood as fate, in the sense that it is not the result of free choice but reveals itself in the course of adolescence, and (ii) does not change in any relevant way, nor can it really be changed with lasting effect. Again, other factors or traits of personality may serve as an analogy. It is important to note that this only applies to the inner sexual experience (insistent and involuntary thoughts, dreams and fantasies) and not to sexual interests and expressed sexual behaviour. This distinction is crucial in discussions about a possible change of sexual preference, especially with respect to offending behaviour (Fedoroff, 2016). Sexual behaviour, of course, can change, and so can sexual interests. At around the age of 20, we are generally very well aware of our sexual preference, just as we are aware of our personality in general. At this age, most individuals will be able to describe their sexual preference in a statement such as, 'Actually, I'm only into adult, slim women with long hair and big breasts, and I prefer oral sex, latex and dominant role-play'. The 'actually' indicates that the sexual behaviours the individual engages in can be quite different from the person's sexual preference.

There are other viewpoints on sexual preference not being changeable and it seems as if the debate could gain some momentum (Grundmann et al., 2016; Seto, 2012; von Franqué & Briken, 2016). From a scientific perspective we cannot exclude the possibility that sexual preference in general might be modifiable. In this context we agree to some extent with von Franqué and Briken (2016), who advocate that researchers formulate their statements in this regard as hypotheses and not as an empirical fact. However, not being in the position to call the stability of sexual preference a scientific fact does not mean that the available scientific evidence and clinical experience have no value. It is interesting that the issue of stability or variability seems only to be discussed controversially with respect to a paedophilic preference (Grundmann et al., 2016). Likewise, there is no discussion, let alone controversial discussion, about whether and how, for example, intelligence levels might be changed significantly. Any alleged (or hypothesised) variability of sexual preference would have to be valid for each of the three axes, in the case that one accepts the Three-Axes-Model of Sexual Preference introduced in this chapter. Likewise, changes would have to be possible in any desired direction, irrespective of cultural or legal peculiarities. We invite you to imagine what it would have to take and how probable it seems for your sexual preference to be changed permanently, for example that it is aligned towards prepubescent children of the same sex. As therapists we have to take a position in order to be authentic when offering a certain treatment. In our experience, the vast majority of men with paedophilia were relieved when told they most certainly would have to live with their sexual preference, despite having wanted to get rid of it for many years. For the time being, and especially as therapists, the authors of this chapter share the view of Schopenhauer, to whom the famous saying 'a man can do as he will but not will as he will' is commonly ascribed (Einstein, 2007: 2).

Problem-causing sexual behaviour

Any discussion of sexual experience and behaviour should respect the fact that an evaluation of human sexuality will naturally always be non-objective and non-permanent. The simple reason

being that such an evaluation is reached by individuals, that is, by social beings socially constructing an evaluation. It is dependent on the culture in which it takes place and it is under the influence of constant cultural change.

Given the prevalence of people seeking professional help for PCSB, and in recognition of the current empirical knowledge, we believe that it is useful to adopt a concept of PCSB that focuses on the function that the behaviour is serving. The more someone engages in the PCSB in order to realise a specific sexual preference, and the more pronounced this sexual preference is, the more likely it is that the sexual experience will be highly arousing. The behaviour can appear as 'nonparaphilic' or 'paraphilic', depending on the make-up of the sexual preference. In other words, if the lust dimension of sexuality were in the foreground, the most useful approach to dealing with the behaviour would be to focus on sexual preference issues. The best basis for taking responsibility for a sexual behaviour and, ultimately, controlling it successfully, is full awareness, acceptance and integration of the sexual preference into the personality.

In contrast, the less the PCSB mirrors the sexual preference of the person, or the less the sexual activity is experienced as arousing, the more likely it is that the sexual activity will represent an inadequate attempt to cope with other issues. Accordingly, the most useful approach to dealing with the behaviour here would be to focus on the underlying issues, for example low self-esteem, loneliness, anxiety or depression. It is possible, of course, that an individual with a 'paraphilic' preference uses PCSB as an inadequate coping strategy, painting the sexual activities with the colour of the preference. In this case it would be important not to overemphasise the preference at the cost of ignoring other underlying psychological issues.

Irrespective of sexual preference, some people attempt to compensate for negative emotional states through anti-depressive or anxiety-reducing sexual activity. In neurotic compensation, however, enough is never enough and more is always more. Compensation inevitably implies that the actual needs are not met, so the compensatory behaviour (reinforced by sexual arousal) tends to increase, eventually leading to (addiction-like) excess. As is our understanding, here lies the core of the psychoregulatory role of PCSB, independently of a possible (pathologically) accentuated sexual preference.

Conclusion

We believe that reporting findings or referring to reported findings of alleged relationships between 'sex addiction' and 'paraphilias' (for example, 'among sex addicts, x per cent also present a certain paraphilia') could confuse our understanding of both concepts more than it would inform us.

More importantly, we are concerned that addictive, hypersexual, impulsive, compulsive or obsessive behaviour is referred to as sexual behaviour solely on the basis that it visibly manifests itself in the sexuality arena. The extent to which the behaviour actually is an expression of the individual's sexuality, in terms of a manifestation of sexual preference, often remains unclear. By definition, this is clear in regard to paraphilic behaviour.

If we were to continue trying to compare paraphilic with nonparaphilic 'sexual addictions', we would need to look at the reasons for engaging in the behaviours. We would need to confirm that a person engages in nonparaphilic behaviours because of the activities' nature or phenomenology (as is the case for paraphilic behaviours), rather than engaging in them because the sexual activities are rewarding for the experience of sexual arousal and its positive short-term effects (for example, reducing feelings of loneliness).

However, we believe the differentiation of paraphilic and nonparaphilic 'sexual addictions' is not very helpful because we assume that so-called sex addicts have more non-sexual motives for

engaging in the respective behaviour. Thus, the use of the terms 'paraphilic' and 'nonparaphilic' seems unjustified. As Goodman concluded, '[sexual addiction] is simply [...] the compulsive dependence on some form of sexual behaviour as a means of regulating one's feelings and sense of self' (Goodman, 1992: 312). The high rates of co-morbidity with other addictive disorders, mood and anxiety disorders and personality disorders found in so-called sex addicts also seem to support this view (Coleman et al., 2003; Goodman, 1993; Kafka & Hennen, 2002; McElroy et al., 1999; Raymond et al., 2003; Schneider & Schneider, 1990).

For the time being, in dealing with so-called sexual addiction, the focus should not be on what a person imagines or fantasises when engaging in sexual (self-) stimulation. Instead it should be on the role that the sexual (self-) stimulation plays in the person's psycho-regulation.

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