The Routledge International Handbook of Sexual Addiction

Edited by Thaddeus Birchard and Joanna Benfield

Oxon, NY 2018

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

1.3

Sexual addiction

Terminology, definitions and conceptualisation

Gerard A. Schaefer and Christoph J. Ahlers

The phenomenon of concern

In 1986 the Sexuality Information and Education Council of the United States (SIECUS) devoted an issue of their bimonthly report (with contributions by Patrick J. Carnes and Eli Coleman) to the professional controversy and ongoing debate over what terminology might best describe the phenomenon that was, and still is, commonly referred to as sex addiction, compulsive sexual behaviour or hypersexuality (The SIECUS Report, 1986). By that time, the phenomenon had long entered pulp fiction (for example, *The Sex Addicts* by William Donner, 1964). Various therapeutic self-help groups such as Sex and Love Addicts Anonymous, Sex Addicts Anonymous, Sexaholics Anonymous and Sexual Compulsive Anonymous had already become operational between 1976 and 1982. Jim Orford's critical account of both the concept of hypersexuality and the dependence model of sex had been published in the late 1970s (Orford, 1978). The phenomenon had actually already been addressed 100 years earlier within the new field of sexology by Krafft-Ebing (1886). As appropriately pointed out by others (Briken et al., 2005; Hartmann et al., 2014), the popularisation of the problem by labelling it sexual addiction (Carnes, 1983) clearly constitutes a rediscovery.

In another SIECUS Report almost 20 years later, Coleman noted that clinical sexologists 'appear unable to reach consensus on what to call or how to treat such sexual behaviour. [...]. The terminology often implies different values, attitudes, and theoretical orientations, and we remain in a quagmire about classification, causes, and treatment' (Coleman, 2003: 12). The same report, however, also gave rise to hope that 'the days of heated rhetoric appear to be coming to an end. We may finally give problematic sexual behaviour the serious attention it requires – unencumbered by politics, personalities, or dogma' (Sugrue, 2003: 4). Sugrue's optimism arguably is based on a meeting of 50 invited participants who 'spent two intense days discussing how to develop terminology and diagnostic criteria for problematic hyper-sexuality. The group was able to move beyond the sticking point of whether we were talking about an addiction, a compulsion, or an impulse disorder' (Sugrue, 2003: 4).

This optimism proved to be premature. As Rosenberg and colleagues (Rosenberg et al., 2014) point out, the critical reference Orford made in 1978 regarding the difficulties of separating normal and abnormal sexual behaviour, determining when loss of control occurs and assessing

the role of culture in all this is still relevant today. Very recently, others have confirmed the persistence of little consensus (Derbyshire & Grant, 2015; Kraus et al., 2016) and have even spoken of current research as being 'in its infancy' (Kor et al., 2013: 27), and that 'the field should start dialogue' (Reid, 2015: 224). Undoubtedly, none of the terms or conceptualisations that have been used and discussed over the past four decades is accepted by a notable majority of therapists and/or researchers.

The lack of consensus regarding terminology, definition and conceptualisation clearly affects operationalisation, measurement and, consequently, comparability of research results. Research conducted on sexuality is often complex and usually underfunded. Despite these circumstances, the apparent current status after almost 40 years of controversy calls for an unbiased analysis of the factors that have been contributing to the aforementioned quagmire. This applies all the more as the controversies are not limited to questions about what is the most appropriate terminology, diagnostic label or conceptualisation (for example, an addictive disorder, a psychosexual developmental disorder, an impulse control disorder, a mood disorder or an obsessive compulsive disorder). There is strong opposition in general to the conceptualisation of the respective sexual behaviour patterns as a mental disorder (for example, Braun-Harvey & Vigorito, 2015; Klein, 2003; Ley, 2012; Reay et al., 2015). Building on the critique by Ryan and Jethá (2010: 7) of what they call the 'standard narrative of human sexual evolution', it could even be argued that the phenomenon, to some extent at least, may represent natural human sexuality, once it is liberated from the moral restrictions that were put in place fairly recently, in evolutionary terms. Although the title of this book may suggest the existence of a consensus for the concept of sexual addiction, the book, to the credit of the editors and publisher, contains an entire sub-section devoted to alternative discourses.

Controversy and terminology

There is no dispute among therapists, researchers and society in general about the reality of the phenomenon, that is, there are individuals who are distressed because they perceive they have a lack of control over their sexual behaviour. There is also no dispute about the benefit, if not need, of finding a consensus regarding terminology, conceptualisation and theory with respect to this phenomenon. This, however, is unlikely to happen unless more research helps us to better understand it. How, though, can we make sure the same phenomenon is being researched and that the results are comparable if we do not speak the same language? Perhaps it might help to first agree on the nature of the phenomenon in principle, and then find a term that takes into account most of the critique. In a second step, criteria could be agreed on for conducting research and reporting results in order to improve comparability. These two steps need neither research funds nor a listing in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

We, the authors of this chapter, would argue that the phenomenon of concern is essentially 'people who continue to engage in sexual activity despite negative consequences'. We believe a term that is used to describe the heterogeneous group of sexual activities should be applicable to the vast majority of cases for pragmatic reasons alone. In considering both the lack of consensus and diverse critique, the medicalising terms 'compulsive', 'impulsive', 'obsessive' and 'addictive' might best be avoided. The DSM-5 defines hypersexuality imprecisely as a 'stronger than usual urge to have sexual activity' (American Psychiatric Association, 2013: 823). The prefix 'hyper' suggests there is consensus about what constitutes a 'usual' urge or a 'normal' frequency of behaviour. However, to the authors' knowledge, such a consensus that is both transparent (as in published) and based on research is non-existent. The term 'hypersexual' might therefore also best be avoided. We would argue that none of the terms 'problematic', 'high-frequency', 'out of control' or 'distressing' are really suitable because too many cases might then not fit the category. For

example, the behaviours of concern per se – that is, the sexual activity or act itself (irrespective of frequency) – can be problematic, but need not be. Engaging in unprotected genital activities with strangers arguably constitutes problematic sexual behaviour; masturbation arguably does not; neither perhaps does watching pornography or having affairs with multiple partners, if you are single. The behaviour can be high-frequency, but need not be. Buying the services of a high-class escort does not constitute high-frequency behaviour if we are talking about two or three events per year, but such behaviour can cause problems if an individual cannot resist the temptation or urge, despite wanting to stop. Finally, to what extent must an individual fail to control an urge to meet the out of control criterion: is it 75 per cent of the time, or perhaps 90 per cent?

We suggest the descriptive term 'problem-causing sexual behaviour' (PCSB) because it captures the essential consequence of the phenomenon without disrespecting or offending individuals who are directly affected by it. We have in mind here the actual patients, and not their partners or others involved. The behaviour must cause distress to the person, otherwise treatment-seeking and change-motivation would not really be expected to be intrinsic. Furthermore, the term PCSB seems the least likely to provoke opposition among fellow therapists and researchers. There are, of course, other sexual behaviours and sexual behaviour patterns that also cause problems but would not fall into this category. However, we already have established terminology to describe these sexual behaviours and to differentiate them from PCSB, for example, 'high-risk sexual behaviour', 'paraphilic (disorder) behaviours', or 'dissexual behaviours'.[1]

The suggested term, PCSB, also takes into account our notion that the literature on this topic seems to exclusively concern observable behaviour, begging the question why fantasies and urges are part of the various conceptualisations. We were not able to find articles that dealt exclusively with sexual fantasies or sexual urges in the sense that the proposed addiction was uniquely to an inner experience. Here, inner experience is not to be confused with the relief of a negative emotional state, which is often characterised as the ultimate goal of sexual activities for people with PCSB. Rather, inner experience refers to the internal mental process that constitutes a sexual fantasy. Even the so-called fantasy sex addict is not addicted to a fantasy per se; in the long version of the Sexual Dependency Inventory – Revised, *SDI-R The Ten Types*, by Carnes, it is stated that 'although a wide variety of *behaviours* characterize the so called fantasy sex addict, the most common include chronic and compulsive masturbation which may or may not include pornography' (IITAP, 2016: 1; italics added). Others have noted that internet pornography 'was the most widely endorsed manifestation of hypersexual behaviour in a DSM-5 field trial' (Kor et al., 2013: 30). There seem to be very few, if any, cases of individuals who do not engage in socio-sexual or solitary sexual physical activity but are distressed or impaired because they cannot distract themselves as often as they would like to from their focus on (non-deliberate or unintentional) sexual fantasies or urges. It is also against this background, that the label 'hypersexual disorder' seems ill-chosen, as it refers to a 'stronger than usual' *urge*. However, the apparent disorder is all about behaviour.

Several variables may help us to further differentiate the heterogeneous group of individuals who engage in PCSB. Briken and colleagues (Briken et al., 2013) point out that, while disagreements about what constitutes non-normative sexual behaviour may evolve due to cultural change, they lean towards qualitative and quantitative characteristics. Although the authors apply this to paraphilic disorders (qualitative characteristics) and hypersexual disorders (quantitative characteristics), the categories are useful for further investigating PCSB. Kafka's proposed definition of hypersexual disorder includes six specifiers, namely masturbation, pornography, sexual behaviour with consenting adults, cybersex, telephone sex and strip clubs (Kafka, 2010), all of which can be seen as qualitative features of PCSB (again, fantasy does not appear as a separate specifier). Kafka proposes two criteria for diagnosing hypersexual disorder, both of which offer

some more qualitative features. These include the questions of whether we are dealing with fantasies, urges or behaviours, or any combination thereof (Criterion A), and which areas of functioning are impaired (Criterion B). Further qualitative features could be solitary and impersonal activities versus interpersonal activities (with varying degrees of intimacy). While intensity can also be seen as a qualitative characteristic, and clearly is a more subjective feature than frequency, it is a measurable feature. Thus, we suggest that agreement is needed on scales that allow for measuring and comparing characteristics of PCSB that are essentially quantifiable, such as frequency, recurrence, intensity, level of control and level of distress or extent of impairment. Some of these and other features have been grouped into concepts of severity (Reid, 2015) and respective rating scales have been developed (see Y-BOCS, Goodman et al., 1989). The extent to which these scales might be suitable is open to discussion.

Conclusion

It is surely too early to report a reliable prevalence of the sexual behaviour patterns referred to in this book as representing a sexual addiction. The demand for treatment, however, is indisputable. The amount of attention that both researchers and therapists have given the phenomenon, especially since the late 1970s, may serve as a clear indication of this. The rather prominent – and for that matter quite understandable – role that the described sexual behaviour patterns arguably play in coping with negative emotional states further seems to justify the expectation that the phenomenon will continue to become even more predominant, given the rising prevalence rates of the associated mood disorders.

In view of an increasing demand for treatment the important question to ask, in our opinion, is no longer about the model that might best explain these sexual behaviour patterns. Instead, in addition to improving the comparability of research results, the focus should change to how best to help individuals seeking treatment. In their comprehensive review, Garcia and colleagues conclude that 'current evidence is insufficient to guide clinicians in terms of the best techniques and duration for a given patient with sexual addiction' (Garcia et al., 2016: 68). 'Currently, the best practice in psychotherapeutic treatment of sexual addiction is based on a few uncontrolled studies and case reports. The level of evidence is the lowest possible and is based mostly on expert opinion.' (Garcia et al., 2016: 67).

The current status of PCSB may be described as a lack of consensus regarding conceptualisation and terminology on the one side, and scarcity of empirical data on efficacy and effectiveness of psychotherapeutic approaches on the other. Much of the portrayed controversy has been led by experts in their field, and it often takes many years of dedication and commitment to attain that expert status. To what extent, then, is the current status the result of 'expertee-ism'? It is somewhat ironic that, from a bird's eye view, the discussion since the 1970s could look as if (groups of) individuals have been trying to consolidate the concept to which they are each 'addicted'. The effect of this subjectivity may be amplified by the nature of the topic being sexuality; our understanding of sexual experience and behaviour is socially constructed and culture dependent. Presumably there is nothing more personal and intimate than our sexuality and, thus, nothing more difficult to detach from. To what extent, then, is the current status the result of insufficient reflection on how our own (understanding of and view on) sexuality affects our clinical observations and the research we conduct?

According to Albert Einstein, the definition of insanity is doing the same thing over and over again and expecting different results. If our goal remains to make progress in understanding PCSB and how it is best treated, then we can only benefit from changing how we are trying to

achieve it. Continuing to discuss and argue about which explanatory model or concept is superior or more valid will clearly not do the job.

Note

1 'In terms of identifying socially-dysfunctional forms of sexuality – regardless of the legal valuation – dissexuality is defined as an expression of social failure in sexual behavior' (Beier, 1998: 133). Referring to such sexual behaviour as 'dissexual behaviour' offers the possibility to communicate without comparing different legal systems or using legal terminology.

Bibliography

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association.

Beier, K.M. (1998) 'Differential typology and prognosis for dissexual behaviour – a follow-up study of previously expert-appraised child molesters', *International Journal of Legal Medicine* 111, 3: 133–41.

Braun-Harvey, D. and Vigorito, M.A. (2015) *Treating Out of Control Sexual Behavior: Rethinking Sex Addiction*, New York: Springer Publishing Company.

Briken, P., Hill, A. and Berner, W. (2005) 'Sexuelle Sucht: Diagnostik, Atiologie, Behandlung', Zeitschrift für Sexualforschung 18: 185–97.

Briken, P., von Franqué, F. and Berner, W. (2013) 'Paraphilie und hypersexuelle Störungen' in P. Briken and M. Berner (eds) *Praxisbuch sexuelle Störungen*, Stuttgart: Georg Thieme Verlag KG.

Carnes, P. (1983) *Out of the Shadows: Understanding Sexual Addiction*, Minneapolis, MN: CompCare Publications.

Coleman, E. (2003) 'Compulsive sexual behaviour: what to call it, how to treat it?', *SIECUS Report* 31, 5: 12–16.

Derbyshire, K.L. and Grant, J.E. (2015) 'Compulsive sexual behaviour: a review of the literature', *Journal of Behavioral Addictions* 4, 2: 37–43.

Donner, W. (1964) *Sex Addicts*, Las Vegas: Stardust Reader, Pioneer Publishing.

Garcia, F. D., Assumpção, A. A., Malloydiniz, L., Corrêa De Freitas, A. A., Delavenne, H. and Thibaut, T. (2016) 'A comprehensive review of psychotherapeutic treatment of sexual addiction', *Journal of Groups in Addiction & Recovery* 11:1, 59–71.

Goodman, W.K., Price, L.H., Rasmussen, S.A., Mazure, C., Fleischmann, R.L., Hill, C.L., Heninger, G.R. and Charnery, D.S. (1989) 'The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability', *Archives of General Psychiatry* 46, 11: 1006–11.

Hartmann, U., Mörsen, C. P., Böning, J. and Berner, M. (2014) 'Exzessives Sexualverhalten' in K. Mann (ed.) *Verhaltenssüchte*, Springer-Verlag Berlin Heidelberg.

IITAP. The International Institute for Trauma and Addiction Professionals. Online. Available at: www.iitap.com/documents/SDI-R%20The%20Ten%20Types%20-%20Long%20Version.pdf (accessed 04 March 2016).

Kafka, M.P. (2010) 'Hypersexual disorder: a proposed diagnosis for DSM-V', *Archives of Sexual Behaviour* 39: 377–400.

Klein, M. (2003) 'Sex addiction: a dangerous clinical concept', *SIECUS Report* 31, 5: 8–11.

Kor, A., Fogel, Y.A., Reid, R.C. and Potenza, M.N. (2013) 'Should hypersexual disorder be classified as an addiction?' *Sexual Addiction & Compulsivity* 20, 1–2: 27–47.

Krafft-Ebbing, R. (1886/1965) *Psychopathia Sexualis*, New York: Paperback Library.

Kraus, S.W., Voon, V. and Potenza, M.N. (2016) 'Should compulsive sexual behavior be considered an addiction?' *Society for the Study of Addiction*, doi:10.1111/add.13297 (accessed 28 February 2016).

Ley, D.J. (2012) *The Myth of Sex Addiction*, Plymouth: Rowman & Littlefield.

Orford, J. (1978) 'Hypersexuality: implications for a theory of dependence', *British Journal of Addiction* 73: 299–310.

Reay, B., Attwood, N. and Gooder, C. (2015) *Sex Addiction: A Critical History*, Cambridge: Polity Press.

Reid, R.C. (2015) 'How should severity be determined for the DSM-5 proposed classification of Hypersexual Disorder?', *Journal of Behavioral Addictions* 4, 4: 221–5.

Rosenberg, K.P., O'Connor, S. and Carnes, P. (2014) 'Sex addiction: an overview' in K.P. Rosenberg and L.C. Feder (eds) *Behavioural Addictions. Criteria, Evidence, and Treatment*, Elsevier: Academic Press.

Ryan, C. and Jethá, C. (2010) *Sex at Dawn: How We Mate, Why We Stray, and What it Means for Modern Relationships*, New York: Harper Collins.

SIECUS. Sexuality Information and Education Council of the United States (1986) *SIECUS Report* 14, 6. Online. Available at: www.siecus.org/index.cfm?useaction=Page.ViewPage&PageID=1275 (accessed 23 February 2016).

Sugrue, D.P. (2003) 'Giving problematic sexual behaviour the serious attention it requires', *SIECUS Report* 31, 5: 4.

1.4

A biopsychosocial approach to sex addiction

Paula Hall

Introduction

The field of addiction, and in particular sex addiction, is rapidly changing and society and professionals continue to grapple with whether a medical, psychological or social model is most appropriate. By adopting a biopsychosocial approach, therapists can be encouraged to adopt an eclectic, comprehensive model for both assessment and treatment that addresses the complexities of individual cases. Furthermore, viewing sex addiction through a biopsychosocial lens allows the problem to be understood and viewed in an integrative and holistic way, with regard to how a person becomes involved in addictive behaviour, stays involved in addictive behaviour and stops the addictive behaviour. A biopsychosocial view can also be helpful when working with partners to enable them to understand the problem from a wider perspective and focus on their recovery.

Sex addiction is considered by some to be a myth, a by-product of culture, social influences or another mental health disorder (Klein, 2012; Ley, 2012; Moser; 2013). Some suggest that non-relational and excessive sexual desire has been pathologised by our dominant heterosexist, monogamous discourses (Ley, 2012). This view has perhaps been compounded by the number of religious communities involved in addiction recovery who often promote sex within an intimate relationship as the only form of healthy sexual expression. In order to allay these views and ensure accurate clinical diagnosis and appropriate treatment approaches, therapists can benefit from being aware of both the societal and cultural context within which a patient brings their concerns, and equally as important, we as therapists can become aware of the unconscious messages that may influence our response.

This chapter explores a variety of common addiction models and outlines the benefits to patients, practitioners and other professionals in adopting a biopsychosocial approach.

Models of addiction

Sex addiction is not only controversial, it is also complex. Arguments continue over whether or not 'addiction' is an accurate label and opponents often cite psychological and/or social factors