

## About The Writer



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## Sexual Addiction, Hypersexual Disorder and the DSM-5: Myth or Legitimate Diagnosis?

Feature Articles

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There will always be controversy--as there should be--when any form of inherently healthy human behavior such as eating, exercise or sex is clinically designated as pathological. And while the power to "label" must always be carefully wielded to avoid turning social, religious or moral judgments into diagnoses (as was homosexuality in the *DSM-I* and *DSM-II*), equal care must be taken to not avoid researching and creating diagnostic criteria for nonpathological healthy behaviors should they go awry due to underlying psychological deficits and/or early trauma.

### Is Sex Addiction Real?

Preliminary sexual addiction research in the 1980s suggested that approximately 3% to 5% of the adult population then struggled with some form of addictive sexual behavior. The individuals studied at that time were a self-selected, mostly male group who entered residential treatment due to negative consequences experienced from self-described "years of being hooked" on magazine and video porn, multiple affairs, prostitution, old-fashioned phone sex and similar behaviors. More recent peer-reviewed, tier-one research indicates that the problem of sexual addiction is escalating, and sexual addiction therapists today almost universally report that their treatment population is both skewing into younger age groups and becoming more evenly distributed among men and women.

Since the late 1990s, clinical literature has indicated that this increase in addictive sexual behavior is closely correlated to the increasing speed with which we are able to access intensely stimulating graphic pornography and anonymous sexual liaisons via the Internet. Thus, it seems highly likely (though updated research is needed) that today's laptops, smartphones, and other mobile devices are significantly contributing to the escalating numbers of vulnerable adults addicted to both pornography and the casual sexual hookups available anywhere, anytime--thanks to streaming video and "friend finder" smartphone apps. For instance, in 2012 nearly anyone with a smartphone can find a GPS-located sexual partner as readily as he or she can find a nearby Italian restaurant by logging on to Ashley Madison (11 million members) or Grindr (4 million members), two of the more popular friend-finder/sex-locator apps.

The simple fact is our ongoing *tech-connect* boom has dramatically increased the average person's ability to affordably and anonymously access endless amounts of highly graphic pornography, casual sexual experiences and online prostitution. This escalating proliferation of nearly instantaneous, easily accessed, intensely arousing sexual content and connections, while a life-enhancing source of sexual pleasure for some, can and does cause tremendous problems for those with pre-existing addictive disorders, social inhibition, early trauma, and attachment and mood disorders, as well as the more profoundly mentally and developmentally ill.

Ironically, at nearly the very same moment that sexual addiction began its technology generated escalation in the early 1990s, the American Psychiatric Association (APA) removed the term "sexual addiction" as a diagnostic indicator when publishing the *DSM-IV* (and later the *DSM-IV-TR*). Consequently, the past 25 years have wrought a rather anguished, aggressively argued, somewhat personality driven and inconsistent history in the attempts of the psychiatric, addiction, legal and mental health communities to accurately research, label and distinguish the problem of excessive adult consensual sexual behavior. During this period, potentially useful "clinical" diagnostic and treatment models with names such as "Sexual Addiction" (Carnes, 1983; 1991), "Sexual Compulsion" (Coleman, 1990; 2003), "Out-of-Control Sexual Behavior" (Kinsey Institute), and "Sexual Disorder NOS with Addictive Features" (*DSM-IV*, 1968) have been used somewhat interchangeably among informed clinicians, 12-step communities and the general public. But in 2012, without a formal, universally accepted diagnosis, this language has about as much clinical credibility as do "Nymphomania" and "Don Juan-ism," the terms used to describe similar issues over a century ago.

Of related concern is the fact that the sex therapy, sex offender and sex addiction fields, all highly evolved specialties that should be working together with shared knowledge and support, are literally at an unresolved and definitive split over whether sexual addiction even exists! One current example is the recent book that spends 250 or so well-written pages implying that sexual addiction/sexual compulsion/hypersexuality is merely:

- a) a false clinical mirror for a repressive, sex negative and moralistic culture
- b) a fake diagnosis that uses repressive, moralistic judgments to make money, fame and fortune for savvy but unethical clinicians
- c) a backlash against healthy male sexuality

- d) an attempt to use a clinical term to reign in less culturally acceptable consensual sexual choices
- e) all of the above

The fact that a book like this has garnered attention highlights the fact that the lack of a formal diagnosis has allowed sexual addiction to become an ongoing catalyst for professional disinformation, clinical acrimony and shared disrespect--all in an area of addiction and mental health care that is in great need of integrative, holistic treatment goals, policy, coordinated research and clinical direction.

### **Sex Addiction and the DSM: A Brief History**

In 1987 the APA's *Statistical Manual of Mental Health Disorders (DSM-III-R)* added for the first time the concept of "sexual addiction" as a term that could be applied when useful to clarify the more general diagnosis of "Sexual Disorders NOS (Not Otherwise Specified)." The *DSM-III-R* then explained that this descriptor could be utilized if the individual being assessed displayed "distress about a pattern of repeated sexual conquests or other forms of nonparaphilic sexual addiction, involving a succession of people who exist only as things to be used." While not yet a full diagnosis at that time, as there were no specific criteria offered to detail this phenomenon, this was a documented early acknowledgement by the APA that some individuals (those not in a manic state and/or influenced by recreational drugs), could nonetheless struggle with addictive sexual behavior patterns.

This early *DSM-III-R* descriptor is, by the way, consistent with language commonly used by those clinicians now treating sex addicts and their spouses, who typically define sexual addiction as repetitive and problematic compulsive or impulsive sexual behavior patterns involving excessive shame, secrecy and/or abuse to self and/or others. Active sex addiction is understood to cause relationship, career, legal, emotional and physical health problems. Left untreated, sex addicts will most often continue their problem patterns of consensual sexual behavior despite repeated attempts to limit or eliminate them, even when facing a history of related, often escalating negative life consequences. And sex addicts engage in these behaviors with and without a related mood disorder or substance abuse problem. In other words, just like alcoholics and drug addicts, sex addicts come both with and without pre-existing conditions.

Unfortunately, subsequent and current versions of the *DSM* (the *DSM-IV* and *DSM-IV-TR*) retracted the above descriptor due to "insufficient research" and "lack of expert consensus," a decision that has left addiction specialists, psychotherapists and the burgeoning sexual recovery community with no accurate name for this problem. At present there are no formally acknowledged mental health criteria to accurately assess, diagnose, and treat men and women with problematic patterns of consensual adult sexual behavior. Despite this, American residential and outpatient psychotherapists and addiction counselors today report a marked increase in the number of clients seeking help for self-reported crises like "I find myself disappearing for multiple hours daily into online porn," or, "I feel lost on a never-ending treadmill of anonymous sexual hookups and affairs," or, "Anonymous sex and porn have lead me to multiple drug and alcohol relapses."

### **What Is it Like To Be a Sex Addict?**

Sex addicts experience a profound, self-induced neurochemical high when fantasizing about and preparing for a sexual act. They describe these feelings of arousal and intensity as akin to being in a "bubble" or trance. This is a time when intense anticipatory fantasy and euphoric recall induce an adrenaline-fueled, dopamine-driven, tunnel-visioned state during which it is increasingly less possible to think clearly and make good decisions. This excitement (which causes rapid heartbeat, shallow breathing, perspiration, pupil dilatation, feelings of euphoria, etc.) makes it nearly impossible to fully engage our prefrontal lobe, the portion of the brain utilized when making sound, intellectually based decisions. The experience of being "in the bubble" is similar to what drug addicts experience when they are on the way to their dealers' house, cash in hand--jittery, not thinking clearly and already "out of self" long before any substance actually enters their body. This trancelike, fantasy-fueled state does not allow for clear intellectual thought, but it does allow the individual to emotionally detach and dissociate from depression, anxiety and uncomfortable feelings related to past trauma and other life stressors--much like what happens to the alcoholic or drug addict when he or she begins the process of drinking or using. In other words, sex addicts abuse their own neurochemistry in much the same way that alcoholics abuse alcohol and drug addicts abuse cocaine, heroin or crystal meth.

Sex addicts describe this anticipatory state of consciousness as a more powerful experience than the sex itself--and it can certainly last longer. (In the same way, compulsive gamblers say that playing is a more powerful experience than winning.) For sex addicts, actually having sex and the resulting orgasm is not the primary objective of acting out. The subconscious meta-goal is to lose oneself for as long as possible by dissociating into the excitement that comes from playing the game. In fact, achieving orgasm is often delayed for an extended period, as it marks the endpoint of the addict's emotional high. After orgasm the individual's neurochemistry returns to baseline, and he or she is then left with the same emotional challenges and stressors that led to the addict's acting out in the first place. Ultimately, the real goal for the sex addict is to lose himself or herself in the ether of euphoric emotional (as opposed to genital) arousal for as long as possible.

### **Who Is a Sex Addict?**

Being sexually addicted is not positively correlated to being male or female, gay or straight, Asian, African or Caucasian, rich or poor, smart, good-looking, successful or anything else. Sex addicts don't stop acting out when they enter a primary relationship--at least not for long--nor do they stop if they become a parent or find their dream job. In a typical example of addict powerlessness, sex addicts often describe themselves as thinking and saying things like, *This is the last time that I am going to go to this sex shop, download that sex-finder app, see my affair partner, or lose time on that porn site*. But ultimately, because they are "out of control" with their sexual behavior, they return to the same or similar sexual situations despite the fact that these behaviors often produce negative life consequences and frequently go against their underlying values and beliefs. As such, most sex addicts end up leading secretive "double-lives," keeping their sexual acting out hidden from friends and family alike, and living compartmentalized existences. To tolerate this duality, sex addicts, like all addicted people, create an ever-expanding web of lies, secrecy, manipulation, rationalization and denial. This disintegrated lifestyle often leads to associated mood disorders, relationship dysfunction and eventual life crises.

Typical sexual addict "acting out" behaviors include, but are not limited to, the following:

- Repeated patterns of multiple affairs and brief "serial" relationships
- Endless hours spent abusing Internet and other pornography
- Compulsive masturbation, with or without pornography
- Regularly recurring (and hidden) attendance at strip clubs, adult bookstores and related environments
- Consistent hiring of (or becoming) prostitutes, escorts and sensual massage practitioners
- Seeking to feel loved, adored and special through interaction with prostitutes, multiple affair partners and similar nonintimate encounters
- Obsessive online and smartphone searches for sexual/romantic partners, with or without a subsequent hookup
- Patterns of anonymous or casual sex with people met online, via smartphone hookup apps or in person
- Unsafe and/or physically dangerous sexual practices
- Involvement and/or membership in sexually focused environments (sex clubs, swingers clubs, bathhouses, etc.)
- Seeking out and having sex regardless of potential immediate or long-term consequences to self or others

Sex addicts typically experience:

- Loss of control over escalating sexual fantasies and behaviors
- Increasing frequency and intensity of sexual thoughts and behaviors over time (escalation)
- Significant and escalating amounts of time lost to sexual fantasy and acting out
- Depleted creativity, intimacy and/or recreation (outside of sex and the search for sex)
- Irritability, defensiveness and anger when confronted about or when attempting to stop sexual behaviors (withdrawal)
- Social and emotional isolation
- Related mood and relationship disorders
- Lack of empathy for how sexual behavior may affect spouses and partners
- Negative consequences (relationship, emotional, physical, financial, legal, etc.) directly related to sexual acting out

### **What Sexual Addiction Is Not**

Sexual addiction is not determined utilizing a predetermined moral or religious agenda, nor is it diagnosed simply because one's sexuality lies outside of culturally acceptable norms (monogamy being one such example). Sexual addiction is not delineated by fetishistic or paraphilic patterns (cross-dressing, BDSM, etc.) or by homosexual/bisexual sexual arousal patterns or behavior--even if these arousal patterns are unwanted by the individual (ego-dystonic). Similar to the sex addict, those with ego-dystonic arousal patterns may keep sexual secrets, feel shame or distress, and even feel out of control related to their sexual behavior, but this alone does not make one a sex addict. Sexual addiction is not defined by what or whom the individual finds arousing, nor is it defined by how often they desire to have sex. Sexual addiction is also not defined by the random one-night-stand, marital infidelity or the occasional visit to a strip club with friends.

Sexual addiction is defined by persistent and profound sexual and romantic objectification of self and others, combined with repetitive patterns of sexual urges, fantasies and behaviors that create personal distress and impairment. These sexual and romantic behavior patterns are abused by the individual in a maladaptive attempt to self-medicate and to provide emotional self-stability while offering a sense of control over how the individual meets his or her basic, human dependency needs. Over time these behaviors offer a decreasing return on a profound investment of time, energy, money and focus, including time not spent in self-care, in recreation, with family and in intimate relationships. These patterns persist despite ongoing and related damage to career, education, relationship, family and other important life goals.

### **How Does Sex Become an Addiction?**

Sexual addiction is considered to be a process or behavioral addiction, similar to compulsive gambling, exercise addictions and compulsive spending. Sex addicts typically struggle with underlying emotional or psychological problems often stemming from early life abuse such as physical or sexual trauma and emotional neglect. Male sex addicts more frequently report profound histories of covert childhood emotional abuse (being used emotionally by a parent or caretaker to buoy that parent's ego strength, sense of self and emotional stability), whereas female sex (and relationship) addicts are more likely to report histories of overt childhood sexual and/or physical abuse. In addition to their adult sexual problems, such individuals,

while often intellectually intact, report correlated struggles with substance abuse/dependency, anxiety, low self-esteem, poor social skills and mild to major depression, among other mental health concerns. Those with pre-existing social, personality and attachment deficits are highly represented among sex addicts.

Sexual addiction is in essence a symptom of underlying profound adult challenges with intimacy and attachment, stemming both from genetic and environmental sources. Sex addicts have difficulty making use of the soothing containment provided by healthy adult attachment and will instead turn to intensity-based, objectified sexual and romantic experiences for comfort. Alice Miller in her groundbreaking book *The Drama of the Gifted Child* explores the issue in this way: "The child who is used and/or abandoned emotionally by their parent has the chance to develop his intellectual capacities undisturbed, but not the world of his emotions and this will have far-reaching consequences for his well-being."

### **What Does the Future Hold?**

Ironically, at the same time the APA backed away from both defining and providing the research dollars needed to help define addictive sexual behavior, the concept of sex addiction has gained widespread media and public acceptance as well as grudging therapeutic legitimacy. Driven by a combination of media attention, the international rise of 12-step sexual recovery groups, films and television shows focused on sexual addiction (*Shame*, *Californication*, etc.), and the highly publicized problem sexual behaviors of multiple major political and sports figures, the general public appears to have tentatively embraced the concepts of sex and porn addiction, as well as love or romantic addiction.

Recognizing the need to readdress this issue, the APA has requested and received extensive peer-reviewed, tier-one research data, along with an exhaustive literature review (Shout out to Dr. Marty Kafka of Harvard!) toward its consideration of a potential DSM-5 Hypersexual Disorder diagnosis. While "Hypersexual Disorder" may not be the ideal term for a problem that more accurately involves the lengthy search and pursuit of sexual and romantic intensity rather than just the sex act itself, the proposed criteria as written do point to problem patterns of excessive fantasy and urges that mirror most aspects of what we have come to know more commonly as sexual addiction.

The proposed criteria for Hypersexual Disorder for the DSM-5 read as follows:

A. Over a period of at least six months, recurrent or intense sexual fantasies, sexual urges or sexual behaviors in association with three or more of the following five criteria:

1. Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other important (nonsexual) goals, activities and obligations.
2. Repetitively engaging in sexual fantasies, urges or behaviors in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
3. Repetitively engaging in sexual fantasies, urges or behaviors in response to stressful life events.
4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviors.
5. Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.

B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges or behaviors.

C. These sexual fantasies, urges or behaviors are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication).

Specify if:

*Masturbation*  
*Pornography*  
*Sexual Behavior with Consenting Adults*  
*Cybersex*  
*Telephone Sex*  
*Strip Clubs*  
*Other: examples--prostitutes, strip clubs/adult bookstores*

Thus, hypersexuality is conceptualized as a non-paraphilic sexual desire disorder with an impulsivity component. The proposed behavior specifiers are intended to integrate empirically based contributions from numerous perspectives, including dysregulation of sexual arousal and desire, sexual impulsivity, sexual addiction, and sexual compulsivity.

### **Will the APA Add Hypersexual Disorder to the DSM-5?**

Documented evidence increasingly points toward Hypersexuality Disorder (sexual addiction) being a legitimate, serious and not uncommon clinical condition associated with the related concerns of disease transmission, family and relationship dysfunction,

separation, divorce, anxiety, unplanned pregnancy, mood disorders, job loss and even suicide. Therefore it makes sense that a diagnosis should be imminent and forthcoming. Yet despite the escalating numbers of men and women now seeking both clinical and self-help support in an effort to alter *self-reported patterns of out-of-control sexual behavior*, it seems unlikely that the *DSM-5* Workgroup for Sexual and Gender Identity Disorders will include Hypersexual Disorder as a distinct diagnostic category in the upcoming *DSM-5*. To be fair, it must be acknowledged that the current research literature on hypersexuality/sexual addiction is absent the standards currently utilized to identify an *addictive disorder*, as peer-reviewed, validated research is still lacking in the areas of tolerance and withdrawal--both of which are required to meet all the necessary criteria toward an addictive disorder diagnosis. Significantly more research is also needed related to how this behavioral disorder affects women.

### **If Not Now, Then When?**

A current review of hypersexual disorder research, along with documented evidence offered by treatment providers, demonstrates that the number of researched and reported cases of sexual addiction (as outlined above in the suggested *DSM-5* definition) now greatly exceeds the number of researched and reported cases of several other sexual disorders already classified as DSM diagnoses, such as fetishism and frotteurism. These other disorders, placed in the DSM when standards for inclusion were slightly looser, seem to be grandfathered in, for lack of a better term. That is not to say these aren't legitimate diagnoses, just that hypersexuality as a diagnosis is being held to a higher standard than its sexual disorder predecessors.

In this climate the most ideal outcome would be for the proposed hypersexual disorder diagnosis to be placed in the *DSM-5* appendix under "potential diagnoses requiring further research." While this action would not offer a much needed, criteria-based full diagnosis, it would nevertheless be both useful and deeply meaningful, as being a documented DSM "potential diagnosis" brings both intensified interest in legitimate research and a badly needed increase in research funding.

### **Why Do We Need a Formal Diagnosis?**

What a DSM diagnosis would do is help clinicians to clearly identify individuals who struggle with compulsive, addictive and impulsive sexual disorders, diagnose them properly, and direct them toward useful, accurately planned models of treatment. Furthermore, adding hypersexual disorder to the *DSM-5* would go a long way toward removing the same kinds of moral stigma previously applied to alcoholics, drug addicts and compulsive gamblers before those concerns were fully recognized as treatable addictions and legitimate disorders. Let us not forget that prior to proper diagnosis and treatment planning, alcoholics were simply bums, overeaters were fat and lazy, and compulsive gamblers were too sociopathic to not gamble away the family rent. A legitimate diagnosis removes moral stigma and lessens the chance that a sex addict will be misdiagnosed or have problematic sexual behavior inadvertently normalized.

It should be noted that the proposed hypersexual disorder diagnosis, were it included in the *DSM-5*, would neither add to our nation's tax burden nor raise health insurance rates, as most mental health coverage already excludes psychological treatment for sexual issues. Nor would the diagnosis "take off the hook" or "give excuses for bad behavior to" those men and women whose sexual activities have caused harm to self, loved ones and others. Hypersexuality as a diagnostic criteria also will not and was never intended to provide sexual offenders an easy way out of the consequences (legal and otherwise) for their nonconsensual, violating sexual patterns.

Whether we call it hypersexual disorder, sexual addiction or something else altogether, the problem itself has never been an excuse for bad behavior, nor is it a fun pastime. Sex addicts are absolutely responsible for the hurt and loss left in the wake of their sexual acting out, but having the problem also does not make them bad or unworthy people. A diagnosis would bring a useful retort to those emotionally and psychologically damaging terms such as *nympho*, *slut*, and *pervert*, replacing them with a legitimate, informed diagnostic category from which useful treatment planning and outcome studies can then be drawn.

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