

ADDICTIVE SEXUAL DISORDERS: DIFFERENTIAL DIAGNOSIS AND TREATMENT

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Introduction

Patients who present with excessive and/or unusual sexual urges or behaviors are often a source of confusion to clinicians. In some cases the diagnosis appears clear-cut: The young man who has a history of arrests for exposing his genitals to unsuspecting strangers has a paraphilia, exhibitionism (DSM-IV diagnosis 302.4); a young woman's obsessive, intrusive, and very disturbing sexual thoughts may be one aspect of her obsessive-compulsive disorder (300.3); the 70-year old nursing home patient who gropes any female staff member who gets within touching distance may be exhibiting a loss of judgment secondary to his Alzheimer's disease (290.1) ; another hypersexual patient exhibits pressured speech and grandiosity typical of the manic phase of bipolar type I or II psychosis (296). In each of these cases, the appropriate treatment is guided by the diagnosis.

There are a larger number of cases whose etiology is less obvious, and therefore the therapeutic approach, is less clear. Some examples are: The computer programmer whose job and marriage suffer because he spends many hours daily engaged in viewing internet pornography and dialoguing on-line with similarly- inclined women; the married woman who has multiple affairs despite her fears that the marriage will end; the gay man who has had thousands of anonymous sexual encounters in restrooms and parks with other men, usually without giving any thought to "safe sex" practices until panic sets in after the encounter is over; the clinician who uses his professional practice as a source of women with whom to be sexual; the isolated consumer of home and bookstore pornography whose multiple daily episodes of masturbation have cost him excessive time, money, as well as injuries to his genitalia.

To complicate the picture, many of those who engage in excessive sexual behavior are also pathologically indulgent in other behaviors and activities. Most commonly, they are found to have a concurrent substance use disorder, such as alcohol dependence (303.90), impulse control disorder such as pathological gambling, or an eating disorder. The majority of persons with cocaine dependence (304.20) engage in compulsive sexual behavior as part of their cocaine- using lifestyle (Washton, 1989). Chemical dependency treatment professionals are learning that in order to avoid relapse to chemical use among recovering addicts, all compulsive behaviors must be identified and addressed. Assessment and treatment of addictive sexual behaviors must be an integral part of the chemical dependency treatment.

The goal of this paper is to assist the psychiatrist and the primary care physician to

understand the various disease processes which underlie excessive sexual behaviors and to understand the different treatment approaches which are helpful.

Differential Diagnosis of Addictive Sexual Disorders

The most common types of excessive sexual behaviors can be classified into one of three major Axis I categories: paraphilia, impulse control disorder Not Otherwise Specified (NOS), or sexual disorder NOS. The paraphilias are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects (such as animals or inanimate objects), activities or situations (for example, involving nonconsenting persons, including children, or else causing humiliation or suffering). For some individuals, paraphilic fantasies or stimuli are obligatory for erotic arousal and are always included in sexual activity; in other cases, the paraphilic preferences occur only episodically. In contrast to the Sexual Dysfunctions, which are associated with decreases in sexual functioning, the paraphilias are commonly associated with increases in sexual activity, often with compulsive and/or impulsive features.

Some cases of sexual excess represent an impulse-control disorder, but many cannot be easily classified as either a paraphilia or an impulse-control disorder. If they cause distress to the person, they can be diagnosed as Sexual Disorder NOS. Many such cases can be considered an addictive disorder. The essential features of all substance-use disorders (DSMIV, p. 181) are *behavioral*, consisting of (1) loss of control, (2) preoccupation, and (3) continuation despite adverse consequences. These same criteria can be applied to excessive *behaviors*, obsessive/compulsive behaviors with addictive features. Such reasoning has specific and concrete treatment implications.

Other psychiatric disorders can also be associated with sexual excesses. In addition, axis II characterological disorders (e.g. antisocial personality disorder, narcissistic personality disorder) are often contributory or may be the primary cause of paraphilic or nonparaphilic excessive sexual behavior. The frequent and infrequent DSM axis I diagnoses associated with sexual excesses are presented in Table 1 (Source: Schneider & Irons, 1996, p.17)

Table 1: Differential Diagnosis of Excessive Sexual Behaviors

Common
Paraphilias
Sexual disorder NOS
Impulse control disorder NOS
Bipolar affective disorder (I or II)

Cyclothymic disorder

Post-traumatic stress disorder

Adjustment disorder [disturbance of conduct]

Infrequent

Substance-induced anxiety disorder [obsessive-compulsive symptoms]

Substance-induced mood disorder [manic features]

Dissociative disorder

Delusional disorder [erotomania]

Obsessive-compulsive disorder

Gender identity disorder

Delirium, dementia, or other cognitive disorder.

Patterns of Addictive Sexual Disorders

The word "excessive," as used in this paper, does not specify a particular quantity, frequency, or type of sexual behavior. Rather, what makes these behaviors an addictive disorder is that they all have in common that the patient has expended much time and mental energy in connection with the behavior, has incurred distressing life consequences as a result of the behavior, but has been unable to stop.

Among 1,000 patients admitted for inpatient treatment of addictive sexual disorders, Carnes (1991) discerned ten patterns of behavior, summarized in Table 2:

Table 2: Patterns of Addictive Sexual Behaviors

1. Fantasy sex: Person is obsessed with a sexual fantasy life. Fantasy and obsession are all-consuming.
2. Seductive role sex: Seduction and conquest are the key. Multiple relationships, affairs, and/or unsuccessful serial relationships are present.
3. Anonymous sex: Engaging in sex with anonymous partners, or having one-night stands.
4. Paying for sex: Paying for prostitutes or for sexually explicit phone calls.
5. Trading sex: Receiving money or drugs for sex or using sex as a

business.

6. Voyeuristic sex: Visual sex: Use of pornographic pictures in books, magazines, the computer, pornographic films, peep-shows. Window peeping and secret observation. Highly correlated with excessive masturbation, even to the point of injury.

7. Exhibitionistic sex: Exposing oneself in public places or from the home or car; wearing clothes designed to expose.

8. Intrusive sex: Touching others without permission. Use of position or power (e.g. religious, professional) to sexually exploit another person.

9. Pain exchange: Causing or receiving pain to enhance sexual

pleasure. 10. Exploitive sex: Use of force or partner vulnerable to gain sexual access. Sex with children.

Five of the above categories constitute specific DSM-IV paraphilias: voyeuristic sex, exhibitionistic sex, pain exchange (sexual sadism, sexual masochism), some types of intrusive sex (frotteurism), and exploitive sex (pedophilia). Four of the remaining categories may be correlated with paraphilias: fantasy sex may be associated with paraphilic urges not acted upon, anonymous sex may be used to permit expression of paraphilic behavior with decreased risk of consequences, and paying for sex and trading sex are means by which a partner who may permit paraphilic activities may be purchased. Whether the specific pattern can be diagnosed as paraphilic or nonparaphilic, its compulsive nature often leads to failure of traditional psychotherapeutic techniques to cure it, and success with addiction-based approaches.

Gender Differences

Significant gender differences have been observed in the prevalence of various patterns of addictive sexual behaviors (Carnes et al., 1991). Men tend to engage in behavioral excesses that objectify their partners and require little emotional involvement (voyeuristic sex, paying for sex, anonymous sex, and exploitive sex). A trend toward emotional isolation is clear. Women tend to be excessive in behaviors that distort power -- either in gaining control over others or being a victim (fantasy sex, seductive role sex, trading sex, and pain exchange). Women sex addicts use sex for power, for control and attention (Carnes et al, 1991, Kasl, 1989).

Case 1: A 34-year old woman from a rigidly religious family married an alcoholic. After 2 years of marriage she became involved in what was the first of many extramarital affairs. To prevent detection by her husband, she withdrew from him emotionally and neglected the marital relationship. She recognized that she was not spending enough time with her children, but felt powerless to change. Despite feelings of guilt, she did not seek help until she cheated on her new lover.

Multiple Addictions

Addictive disorders tend to coexist. Nicotine dependency, for example, is highly correlated with alcohol dependence. The same is true of sex and drugs. Addictive sexual disorders often coexist with substance use disorders and are frequently an unrecognized cause of relapse. In an anonymous survey of 75 self-identified sex addicts (Schneider & Schneider 1991), 39% were also recovering from chemical dependency and 32% had an eating disorder. In another study (Washton, 1987), 70% of cocaine addicts entering an outpatient treatment program were found also to be engaging in compulsive sex. In Irons and Schneider's (1994) population of health professionals assessed for sexual impropriety, those with addictive sexual disorders were almost twice as likely to have concurrent chemical dependency (38% prevalence) than were those who were not sexually addicted (21%). Thus, the presence of sexual compulsivity was a comorbid marker for chemical dependency.

Case 2: A 40-year old physician was actively involved in Alcoholics Anonymous and appeared to be doing well until one day when he did not appear at work and was found at home, intoxicated. Suicidal, he explained to his therapist that drinking was not the real problem -- he had been engaging in anonymous unsafe sex with men in public restrooms, and could not stop. He felt such fear and anguish that his only options seemed to be suicide or drinking; he chose alcohol. Sexual issues had not been addressed during his prior inpatient treatment for alcoholism. (Schneider, 1991).

Professional Sexual Exploitation

Sexual contact between a helping professional (e.g., physician, counselor, or minister) and their patients or clients is condemned by professional organizations and licensing bodies, and is considered to be sexual exploitation. Professionals may be sexually exploitative on the basis of 1) naivete and lack of knowledge of appropriate boundaries, 2) circumstances which for a time increase the professional's vulnerability, 3) presence of one or more Axis I addictive disorder, or 4) presence of Axis I mental illness or Axis II character pathology such as antisocial personality disorder. In many cases, the professional has a repetitive *pattern* of sexual exploitation of clients and in fact has an addictive sexual disorder.

Irons and Schneider (1994) reported the results of an intensive inpatient assessment of 137 healthcare professionals referred because of allegations of personal or professional sexual impropriety. After assessment, half (54%) were found to have a sexual disorder NOS with addictive features (i.e., to be sexually addicted). Two thirds (66%) of the entire group were found to have engaged in professional sexual exploitation, and of this subpopulation, two thirds (66%) were sexually addicted. Thus, addictive sexual disorders are a common feature of sex offending by professionals. In addition, 31% of the entire group was incidentally found to be chemically dependent, a condition for which many had not previously been treated.

Case 3: A 52-year old married minister had a long history of sexual involvement with female parishioners who came to him for counseling. His family relationships were distant because he was often away from home in the evenings "counseling" rather than

spending time with his family. After several women came forward with their stories, the minister was fired, evicted from his church- owned house, and publicly humiliated. He resigned from ministerial duties and changed careers.

Treatment

Unlike the goal in treatment of substance use disorders, which is abstinence from use of all psychoactive substances, the therapeutic goal for sex addicts is abstinence only from compulsive sexual behavior. The counselor can help the client identify which sexual behaviors are best avoided. For many sex addicts, masturbation is analogous to the "first drink" which can lead to relapse. Some recovering sex addicts can eventually resume this practice if they restrict their sexual fantasies to "healthy" themes, whereas others need to continue to avoid it.

Because sex addicts were often sexually abused as children (83% according to Carnes, 1991, p.35) and because they have distorted ideas about sex, they frequently lack information about healthy sexuality; education about this subject is highly desirable. In the early recovery period, sex addicts and their partners frequently have sexual difficulties, often to a greater degree than they had during the active addiction phase. Therapists can provide reassurance during this phase. If the compulsive sexual behavior was same-sex, as is surprisingly common even among men who identify themselves as heterosexual (Schneider & Schneider, 1991), therapists can help patients work through issues of sexual identity.

Group therapy is the cornerstone of sex addiction treatment. Shame, a major issue for sex addicts, is often addressed best in group therapy, where other recovering addicts can provide both support and confrontation. Education about sex addiction is a major component of all treatment programs. Several books for laypeople are available (Carnes, Earle & Crow, Kasl, Schneider, and Schneider & Schneider).

The spouse or partner of the sex addict is often overly invested in the relationship and is fearful of abandonment while at the same time being highly critical of the addict. Involvement of the partner in the treatment is highly desirable. In fact, one study found that among married sex addicts, the most important predictor of relapse after inpatient treatment of sexual addiction was failure of the spouse to be involved in the treatment program (Carnes, 1991)

For patients who are suicidal or have other comorbid psychiatric or addictive disorders, or who are unable to recover in an outpatient setting, several inpatient treatment programs are available in the U.S. Most are located in hospitals that also treat substance-use disorders. Increasingly, treatment programs for substance use disorders are now assessing for presence of sex addiction and other addictive disorders, and are either treating the problem themselves or are referring out for such treatment.

Because a large percentage of persons with addictive sexual disorders are also chemically dependent, the initial decision often facing a treatment professional is which addiction to treat first. By the time sex addicts seek help for this disorder, many are already in

recovery from their substance dependence. If not, then regardless of which addiction is primary, the drug dependence must be treated first, or else sex addiction treatment is unlikely to succeed.

The 12 steps of Alcoholics Anonymous have been adapted for use in programs for eating disorders, compulsive gambling, sexual addiction, and other addictions. For those with addictive sexual disorders, attendance at a program dealing with sexual addiction is highly recommended. Several fellowships have evolved, which differ primarily in their definitions of "sexual sobriety." Programs modeled after Al-Anon (the mutual-help program for families and friends of alcoholics) are also available, and attendance by spouses of sex addicts can be very helpful both for the spouse and for the relationship; the two major fellowships have no significant differences. Group support can be a powerful tool for overcoming the shame that most sex addicts and their partners feel. For information about the nearest meetings available in the U.S. and Canada, contact the fellowships listed in Table 3:

Table 3: Twelve-step Programs for Sex Addiction

For the addict:

Sexaholics Anonymous (SA)

P. O. Box 111910

Nashville, TN 37222-6901

Sex Addicts Anonymous (SAA)

P. O. Box 70949

Houston, TX 77270

(713) 869-4902

Sex and Love Addicts Anonymous (SLAA)

P. O. Box 119, New Town Branch

Boston, MA 02258

(617) 332-1845

For the Partner

S-Anon

P. O. Box 111242

Nashville, TN 37222-1242

(615) 833-3152

Codependents of Sex Addicts (CoSA)

9337 B Katy Fwy #142

Houston, TX 77204

(9612) 537-6904

For Couples
Recovering Couples Anonymous
P. O. Box 11872
St. Louis, MO 63105
(314) 830-2600

Professionals and interested patients can also write for information to:
National Council on Sexual Addiction and Compulsivity (NCSAC)
1090 S. Northchase Parkway
Suite 200 South
Atlanta, GA 30067
e mail: ncsac@telesyscom.com
website: <http://www.ncsac.org>

In cases of professional sexual exploitation, it is important to have a thorough assessment to determine the cause. Some exploitative professionals have a better prognosis than others for return to professional practice. In contrast to persons who have exploited primarily as an expression of an axis II characterological disorder, sexually addicted professionals who have successfully completed comprehensive assessment and primary treatment can often return to work without compromising public health and safety. Irons (1991) devised a set of proposed contractual provisions for reentry. Such a contract can be part of a binding legal stipulation between the professional and a state professional licensing board and can define a standard of care for potentially impaired healthcare professionals.

Conclusion

Addictive sexual disorders have distinct parallels with other addictive disorders, commonly coexist with substance-related disorders, may themselves have features associated with addiction, and may respond to an addiction model of treatment and therapy. Unrecognized and untreated symptoms of these sexual disorders are significant factors leading to return to substance use in substance-related disorders. Compulsive sexual behavior has significantly contributed to the growth of the current epidemic of acquired immunodeficiency syndrome. A more detailed discussion of diagnostic and treatment issues and resources may be found in our chapter in a recently published addiction psychiatry textbook (Irons & Schneider, 1997).

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Educational Objectives

1. Visualize where addictive sexual disorders fit into the DSMIV.
2. Get an overview of the spectrum of addictive sexual disorders.
3. Understand the principles of treatment of sex addiction and have access to resources for recovery.

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Questions:

1. Criteria for diagnosis of sexual addiction include all but:
 1. Preoccupation with certain sexual activities.
 2. Continuation of the sexual behavior despite adverse consequences.
 3. More than 50 lifetime sexual partners or more than 2 visits to a prostitute weekly for 6 months.
 4. Loss of control over the sexual behavior.

2. Elements of treatment for addictive sexual disorders include all but:

1. Group therapy.
2. Attendance at self-help programs.
3. Education about healthy sexuality.
4. Avoidance of all sexual activity for at least one year.