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SEXUAL ADDICTION: MANY CONCEPTIONS, MINIMAL DATA

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ABSTRACT. *Sexual addiction has received increasing attention in the past decade. We review existing literature on (a) competing conceptualizations of this syndrome as constituting an addictive, obsessive-compulsive, or impulse control disorder; (b) symptomatology and progression; (c) etiological models; and (d) treatment approaches. Based on this review, we conclude by identifying questions requiring resolution via empirical investigation. © 1998 Elsevier Science Ltd*

INTEREST IN THE CONSTRUCT of sexual addiction was activated around 1983 with the publication of Carnes' book, now entitled *Out of the Shadows: Understanding Sexual Addiction*. This work spurred the publication of a plethora of books and articles about the phenomena associated with excessive sexual behavior. Current estimates of the prevalence of sexual addiction range from 3 to 6% of the U.S. population (Carnes, 1991). To date, most literature on this topic pertains to controversy regarding the nature of and appropriate designation for the syndrome. In contrast, empirical investigations of the validity of the construct, nature of the disorder, and the efficacy of alternate approaches to its treatment are minimally represented.

Lack of a consensus regarding an accurate name for this proposed diagnostic category makes it difficult to track down information on the topic. Pertinent literature appears under such diverse headings as sexual "addiction," "compulsivity," "impulse control," "dependence," and "excessive sexual behavior." This paper reviews the scattered literature to provide an integrated synopsis of current theory and knowledge in this area. The debate over what to call this syndrome will, without doubt, continue and remain unresolved until substantial empirical evidence accumulates to help settle the question. To avoid excessive confusion, we use the term *sexual addiction* as opposed to any other designation, except where we discuss alternate conceptions of this syndrome. This is not meant to imply that we perceive this term as being more appropriate and accurate than alternate ones. It merely acknowledges that it appears to be the most widely accepted one in use at this time, if perhaps only because it was the original designation.

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UNCONTROLLED SEXUAL BEHAVIOR AS A DISORDER

In his influential book, *Out of the Shadows*, Carnes (1983) introduced the idea that there exists a diagnosable disorder, sexual addiction, that stemmed from the inability to adequately control sexual behavior. The concept of sexual addiction has been an ongoing source of controversy. Some authors have raised serious questions about the existence of such a syndrome. Even among those who do recognize the construct as a valid diagnostic entity, there is little consensus about its defining characteristics.

Levine and Troiden (1988) contend that "The diagnosis of sexual addiction or compulsion rests on culturally induced perceptions of what constitutes sexual impulse control" (p. 351). They further assert that "The invention of sexual addiction and sexual compulsion as 'diseases' threatens the civil liberties of sexually variant peoples" (Levine & Troiden, 1988, p. 361). Short of obviously detrimental activities, such as ones that represent health and legal risks, according to the authors, what is seen by some as an addictive syndrome actually constitutes mere stigmatization and condemnation of particular overt sexual behaviors. Sexual addicts, they claim, "do not possess clinical conditions that set them apart from nonaddicts and noncompulsives. They differ in external behavior, rather than internal make-up" (Levine & Troiden, 1988, p. 361).

In contrast, Coleman (1992) cautions that, due to the adverse consequences associated with sexually addictive behavior, "it is dangerous to define compulsive sexual behavior simply as behavior which does not fit normative standards" (p. 323). He asserts that sexual addiction is more than just "excessive" sexual activity. He contends that these behaviors are associated with forms of distress, such as depression, anxiety, guilt, obsessions, intrusive thoughts, and psychosomatic symptoms, which are not typically found in connection with promiscuity alone. Similarly, it has been suggested by many (e.g., Barth & Kinder, 1987; Coleman, 1992; Orford, 1978; Quadland, 1985) that sexual addiction should not be equated or confused with hypersexuality, nymphomania, or Don Juanism, as these conditions consist primarily of excessive sexual activity driven by an inability to be sexually satisfied.

Despite the caveats discussed above, the construct of sexual addiction does not rest primarily on participation in particular *types* of sexual activity. Moreover, the symptoms subsumed under the term extend beyond a mere excess in *frequency* of engagement in conventional forms of sexual behavior. Carnes' (1983) enduring premise is that there exists a constellation of symptoms (Table 1) related to the inability to adequately control sexual behavior. Drawing an analogy to the addictive processes that govern substance abuse, he emphasized that this form of sexual behavior was maladaptive because it *persists despite the risk of substantial potential adverse consequences.* He cites, for example, instances of clients whom he considers to be sexually addicted sacrificing jobs, financial security, and marriages, and contracting life-threatening illnesses as a consequence of their reckless sexual behavior.

DIVERGENT CONCEPTUAL PERSPECTIVES AND TERMINOLOGIES

The advancement of knowledge about and treatment of sexual addiction has been hindered by ongoing debate over how to label the phenomenon. Alternative terms such as sexual addiction (Carnes, 1983; Earle & Crow, 1990; Goodman, 1992; Robertson, 1990; Schwartz & Brasted, 1985) or sexual dependence (Orford, 1978), sexual compulsivity (Allers, Benjack, White, & Rousey, 1993; Fischer, 1995; McCarthy, 1994; Quadland, 1985; Schwartz, 1992), and atypical impulse control disorder, lack of sexual

TABLE 1. Symptomatology Associated with Sexual Addiction

Behavioral symptoms
- Frequent sexual encounters
- Compulsive masturbation
- Seeking new sexual encounters out of boredom with old ones
- Repeated unsuccessful attempts to stop or reduce excessive or problematic sexual behaviors
- Engaging in sexual activities without physiological arousal
- Legal involvement resulting from sexual behavior
- Frequent use of pornography

Cognitive and emotional symptoms
- Obsessive thoughts of sexuality and sexual encounters
- Rationalization for continuation of sexual behaviors
- Guilt resulting from excessive or problematic sexual behavior
- Loneliness, boredom, and/or rage
- Depression, low self-opinion
- Shame and secrecy regarding sexual behaviors
- Indifference to usual sexual partner
- Lack of control in many life aspects (not directly related to sexual behavior)
- Desire to escape from or suppress unpleasant emotions
- Preference for anonymous sex
- Experientially disconnecting intimacy for sex

Compiled from Carnes, 1983; Coleman, 1992; Earle & Crow, 1990; Pincu, 1989; and Schwartz & Brasted, 1985.

control, or sexual impulsivity (Barth & Kinder, 1987; Quadland & Shattls, 1987) have been used or advocated. Each of these terms reflects a disparate conceptualization of the nature of the disorder characterized by inadequately controlled sexual behavior.

Sexual Addiction

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) lists seven criteria of substance dependence or addiction, three of which must be met in order to apply the diagnosis:

1. The person developed a tolerance, or a "need for greatly increased amounts of the substance to achieve intoxication" (p. 176).
2. The person manifests withdrawal symptoms when deprived of the substance or must use the substance in order to relieve or avoid such symptoms.
3. The substance is taken in larger amounts or longer periods than intended.
4. Efforts to stop or reduce use have repeatedly failed.
5. A great deal of time is spent in activities associated with use of the substance.
6. Important activities are given up or reduced.
7. Use of the substance is continued despite knowledge of detrimental effects.

If the term *sexual behavior* is substituted for the word *substance,* varying combinations of all seven criteria can be observed in individuals considered to be sexually addicted (Goodman, 1992). These clients often report an escalation of the severity of sexual activities engaged in as the disorder progresses, withdrawal symptoms such as depression, anxiety, rumination, and guilt, as well as devoting increasing amounts of time

to sexual preoccupations. In addition, they often report failed efforts to stop or reduce the frequency of their sexual activities, spending an inordinate amount of time seeking out potential partners, reducing other activities in order to make time for these involvements, and persisting in sexual behaviors despite knowledge of the potential for contracting sexually transmitted diseases (STDs), including HIV/AIDS, being caught by partners or legal authorities, or being subjected to physical violence.

Carnes (1983) argues that an ongoing pattern of uncontrolled sexual behavior warrants the term sexual addiction because, like substance abuse, it consists of "a pathological relationship with a mood-altering experience" (p. 4). Goodman (1992) takes this definition a step further. He explicitly acknowledged and addressed the dispute over how the syndrome surrounding poorly controlled sexual behavior should be designated. After reviewing the disparate arguments for the terms *compulsivity, dependency,* and *addiction,* he contends that addiction best captures the true nature of the syndrome. Following the semantics of the *DSM-III-R* (American Psychiatric Association, 1987), he contends that inadequately controlled sexual behavior meets the definition of an addictive disorder,

> . . . a disorder in which a behavior that can function both to produce pleasure and to provide escape from internal discomfort is employed in a pattern characterized by 1) recurrent failure to control the behavior, and 2) continuance of the behavior despite significant harmful consequences. (Goodman, 1992, p. 305)

Goodman's (1992) ultimate conclusion is that the syndrome remains the same regardless of what we call it. To date, he states that designation, symptomatology, and, for the most part treatment, have been based upon conjecture, theory, and clinical judgment. He asserts that

> Sexual addiction is thus not a bizarre aberration, nor a new fad, nor even a unique disease. It is simply the addictive process being expressed through sex, the compulsive dependence on some form of sexual behavior as a means of regulating one's feelings and sense of self. (p. 312)

The argument against the appropriateness of the term "sexual addiction" often centers around the legitimacy of expanding the definition of addiction to apply to behaviors that do not involve the use of a substance that produces increasing tolerance with repeated use and withdrawal symptoms upon cessation. Robertson (1990) challenges this view, contending that it is too narrow and fails to account for the non-drug–related variables that influence brain functioning. In his neurobehavioral model of sex addiction, he argues that "Psychological experiences are chemical experiences in the brain" (p. 15). It could therefore be stated that the same changes in brain functioning can be generated by diverse factors, whether they are substance-induced or triggered by behaviors, such as overeating, excessive exercise, compulsive gambling, or uncontrolled sexual activity.

In support of this argument, Robertson (1990) notes that a "runner's high" is a direct result of behavior that causes a change in neurochemicals. Just as a person can become addicted to the changes resulting from cocaine or alcohol, a runner can become addicted to the release of endorphins associated with aerobic activity. Alec et al. (1988) found that compulsive gamblers excreted more norepinephrine in their urine than did nongambling controls. It could, therefore, be postulated that a person can become addicted to a behaviorally elicited "natural" high analogous to the syn-

thetic high brought about by the ingestion of brain-altering substances. In other words, the addiction is to the neurochemical effect of the behavior involved (whether it be ingestion of alcohol or engaging in sexual activity) and not to the activity itself. This may help explain why substance and non-substance–related addictive behaviors are readily substituted for or supplemented by each other within the same individual.

Aside from the direct risks of unprotected and/or anonymous sexual encounters, such as HIV/AIDS, other sexually transmitted diseases, and unwanted pregnancy, the destructive consequences of sexual addiction are similar to those resulting from other addictive disorders (Carnes, 1983). They include emotional withdrawal, difficulty with intimate relationships, legal involvement, isolation, guilt, depression, anxiety, and secrecy. Not all consequences are experienced by all addicts. Some individuals may initially experience no negative consequences of their behavior. Negative repercussions, however, are increasingly likely to be encountered the longer the addiction is allowed to continue.

Sexual Compulsivity

In opposition, Fischer (1995) strongly argues that "labeling sexual problems as addictions and defining them as disorders that can never be fully overcome seems naive at best and self-serving at worst" (p. 5). He charges that the concept of addiction is vague and allows for overdiagnosis. Many of the "self-diagnosed sex addicts," he proposes, "are, in fact, persons suffering from sexually compulsive behavior" (p. 5). Describing an addiction as "medicating," he argues that many of these clients are not attempting to reduce or medicate something painful. He contends, rather, that they engage in the sexual activities in order to "break through their numbness in order to feel something, even if it's painful!" (p. 5).

Coleman (1990) described uncontrolled sexual behavior as "a symptom of an underlying obsessive compulsive disorder in which anxiety-driven behavior happens to be sexual in nature" (p. 12). He charges that utilizing the term sexual addiction is employed as a rationale for advocating therapeutic approaches derived from substance abuse treatment models, such as "12-step" programs. He suggests that addiction is not the proper term for this phenomenon and even goes so far as to call this model dangerous when applied to the treatment of excessive sexual behavior patterns due to "some fundamental differences between the two models that have profound implications" (p. 10). Although he appears to be arguing that addiction models of treatment endanger the individual with uncontrolled sexual behavior because they are not appropriate or effective, he makes this assertion without empirical evidence to support it.

The criteria for a diagnosis of obsessive compulsive disorder (OCD), as listed in the *DSM-IV* (American Psychiatric Assocation, 1994), are: (a) having either obsessions or compulsions; (b) the recognition that either of these are excessive or unreasonable; and (c) that they cause marked distress, are time consuming, or interfere with daily functioning. Obsessions can be defined as a persistent and most often irrational ideas that interfere with daily functioning. The *DSM* designates as compulsions acts that are completed to remove obsessive thought(s) and therefore reduce anxiety.

Obsessions experienced by a sexual addict may include thoughts concerning procuring a sexual partner or finding a location in which to engage in sexual behavior. A variety of sexual behaviors have been argued to constitute compulsions, including excessive masturbation (Earle & Crow, 1990; Kafka & Prentky, 1992; Weissberg & Levay, 1986), difficulty resisting a sexual proposal (Schwartz, 1992), and persistently

surrendering to sexual desires (Barth & Kinder, 1987; Weissberg & Levay, 1986). Often, those suffering from this syndrome realize that their sexual behavior is excessive or disruptive of their daily functioning (Earle & Crow, 1990) and they often experience guilt (Schwartz & Brasted, 1985), negative self-talk (Barth & Kinder, 1987; Earle & Crow, 1990), self-directed anger (Schwartz, 1992), or depressive symptoms (Earle & Crow, 1990) as a result of their sexual activity.

Although in several respects it appears that these phenomena fit clearly within the realm of an obsessive-compulsive disorder, there is one way in which it might be argued that they do not. The *DSM-IV* specifically states that activities that are pleasurable cannot be designated compulsive (American Psychiatric Association, 1994). However, the sexual activities engaged in by sex addicts may, in fact, not be experienced by them as pleasurable. Careful questioning of sex addicts we have worked with clinically suggests that at least some of them repeatedly participate in sexual behaviors *despite* finding them to be *aversive* or *unsatisfying*. (However, their inadequately controlled sexual activity does not appear to be driven by an incapacity to be sexually sated, as in hypersexuality. Many clients who report an absence of pleasure in their "addictive" sexual pursuits indicate that they are satisfied in their more moderate and conventional sexual relations with their partner.) The clinical evidence that sexually addictive behaviors may not be experienced as pleasurable, if supported by empirical research, would suggest that uncontrolled sexual activity is, at least in some cases, consistent with *DSM-IV* criteria for a diagnosis of OCD.

Sexual Impulsivity

According to the *DSM-IV*, the essential feature of an impulse-control disorder is a "failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or others" (American Psychiatric Association, 1994, p. 609). Additionally, there is often an increased sense of tension or arousal before committing the act, gratification or relief at the time of the act, and regret, self-reproach, or guilt following the act. As with addiction or obsessive-compulsive disorder, it appears that the group of symptoms could meet the criteria for this diagnosis. It has been claimed that individuals who repeatedly engage in uncontrolled sexual activity do so despite knowledge that it could be detrimental, while acknowledging experiencing tension or anxiety prior to engaging in the sexual act (Barth & Kinder, 1987; Coleman, 1990, 1991, 1992; Quadland & Shattls, 1987), pleasure or relief during the act, and regret or guilt following the act (Barth & Kinder, 1987; Carnes, 1983; Coleman, 1991, 1992; Quadland & Shattls, 1987).

Shaffer (1994), in summarizing the debate over whether to designate the syndrome an addictive or obsessive-compulsive disorder, writes:

> . . . the value of the concept of an addictive or obsessive compulsive disorder, then, is dependent upon the extent to which an individual patient benefits from its application. While diagnosis is dependent on comparison with groups, choice of treatment must remain prescriptive in application. (p. 17)

This line of argument appears to keep the patient in mind, rather than trying to fit the patient into a predetermined model. In debating what terminology to best apply to the disorder, many authors appear to get caught up in theoretical speculation and to lose sight of the purpose of determining how best to classify the syndrome. The aim of diagnosis is to identify suitable treatment.

Goodman (1992) raised a valid point about the controversy over how to designate uncontrolled sexual activity. He notes that regardless of the term used to describe it, the clinical literature on the topic has been overwhelmingly consistent in the set of symptoms ascribed to the phenomenon. He, therefore, urges that more research be done on the topic. Disagreement about terminology is unlikely to resolve until more empirical study is conducted on what symptoms the disorder actually consists of, the etiology of these symptoms, and the effectiveness of alternate treatment approaches. The information yielded by investigation of these areas can then ultimately lead to a useful designation.

ASSOCIATED SYMPTOMATOLOGY AND PROGRESSION

A study completed by Raviv (1993) compared the symptom patterns, as measured by the Anxiety, Depression, Obsessive-Compulsiveness, and Interpersonal Sensitivity scales of the Symptom Checklist-90-Revised (SCL-90-R), of self-identified sexual addicts ($n = 32$), pathological gamblers ($n = 32$), and nonaddicted controls ($n = 38$). Participants in the sexual addiction group scored significantly higher on all four SCL-90-R scales than the controls, and significantly higher than the pathological gamblers on the Depression scale. While this study suggests that the sexual addict manifests an appreciable level of distress in these areas, there is no way of knowing whether these symptoms contribute to or result from sexually addictive behavior. Nevertheless, the finding of higher levels of symptomatology among self-identified sexual addicts than among the other groups lends some credence to the proposition that this pattern of behavior constitutes a disorder, as opposed to simply consisting of socially disapproved of sexual activities.

Sexual addiction has been alleged to follow a cyclical pattern (e.g., Coleman, 1992; Earle & Crow, 1990; Goodman, 1992; Schneider, 1991; Schwartz, 1992; Wolf, 1988) similar to that of drug addiction. Levine and Troiden (1988) describe the impetus behind sexually addictive behavior in the following terms:

> . . . loneliness, low self esteem, and anxiety cause individuals to lose control over their sexual behaviors, which poses grave threats to ongoing relationships and careers. Despite these risks, sex addicts engage in these practices because they offer temporary relief from psychic distress. This relief is described as a sexual 'fix' or 'high' similar to the ones obtained from illegal drugs, alcohol, or food. (p. 349)

Wolf (1988) contends that a sexual addiction cycle starts with poor self-image due to depression and dissatisfaction with life. Resultant isolation leads to compensatory fantasies and sexual escapism. These fantasies may be acted upon, after which guilt is felt temporarily and then denied, with the resolution that the behavior will not happen again. The self-image is further weakened by self-condemnation for having indulged in sexually addictive activity, augmenting anxiety, and, in turn, feeding the temptation for further engagement in such behavior. Current literature proposes that the cycle of sexual addiction appears to approximate the following path (see Figure 1):

1. Anxiety or other emotional distress is relieved temporarily through engaging in the sexually addictive behavior. The reason the anxiety is reduced may vary, but reduction is the ultimate goal.
2. The anxiety is temporarily reduced.

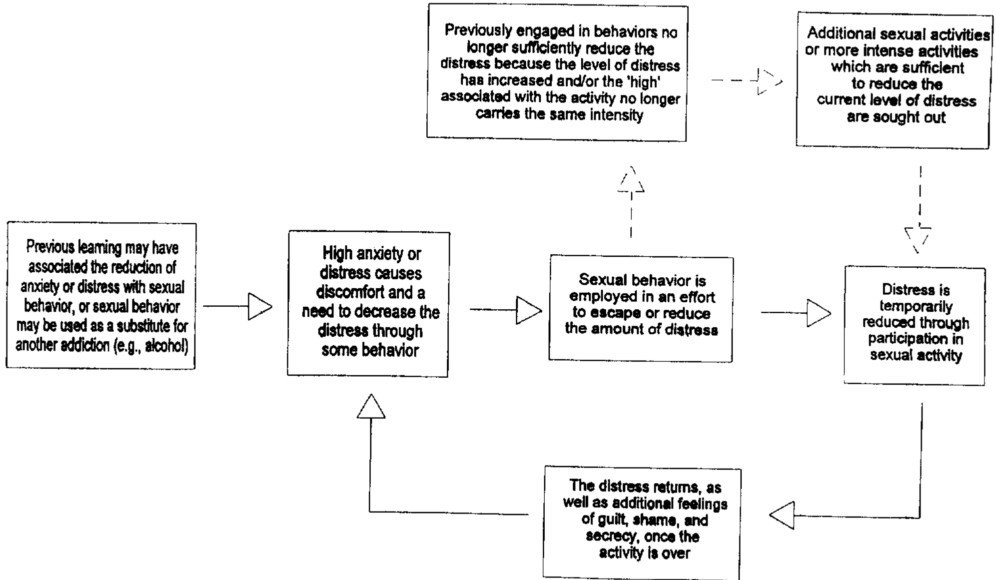

FIGURE 1. Proposed Cycle and Progression of Sexual Addiction.

3. The addiction causes more anxiety, shame, and guilt, as the person creates new difficulties or exacerbates old ones because of his or her behaviors.
4. New and compounded difficulties augment the need to reduce the anxiety.
5. The press to reduce the increased anxiety fosters further engagement in sexually addictive behaviors.

Many researchers and clinicians agree that there is a progression of symptomatology in sexual addiction (Carnes, 1983; Coleman, 1992; Earle & Crow, 1990; Pincu, 1989; Schneider, 1991). Symptoms start with activities that may not be invasive or interfere with occupational, relational, and social functioning. As the disorder progresses, however, these activities are not sufficient to reduce the anxiety, or anxiety is paradoxically increased by distress created by the very activities that were intended to reduce it. Consequently, the individual engages in sexual activities that are progressively more extreme and disruptive to daily functioning.

Carnes (1983) claims that sexual activity escalates to progressively more drastic levels. He proposes the emergence of three distinct levels of sexual addiction as the addiction proceeds. The first level is characterized by relatively victimless sexual behaviors, such as excessive masturbation, consensual sexual activity, and use of pornography. He suggests that in the subsequent level behaviors, such as exhibitionism, voyeurism, and scatologia, become manifest. At the third and final level, he contends, sexual addiction takes the form of victimizing offenses, such as incest and rape.

The practical implications of this conception of sexual addiction as a progressive disorder are immense: Unchecked, sex addiction will, or at least may, evolve into sexual offending. From the perspectives of both the individual's and society's welfare, therefore, the consequences of failing to provide effective treatment for sexual addic-

tion are catastrophic. As dire as this outcome may seem, there is no published empirical research that tests the contention that sexual addiction progresses to sex offending.

CONJECTURES ABOUT ETIOLOGY

Little empirical research has been published investigating the etiology of sexual addiction. There is a general etiological assumption in the literature that many sexual difficulties in adulthood, including sexual addiction, are commonly caused by childhood sexual abuse (CSA). Most existing studies, therefore, aim to examine whether there is such a relationship. Many of them were not designed to investigate sexual addiction alone, but rather to examine sexual problems in general. There are two additional major shortcomings in the design of most of these studies, however, that raise questions about their applicability to sexual addiction. First, there is no uniform definition of the terms "sexual addiction" and "promiscuity," with some investigators using these terms interchangeably. Second, the vast majority of studies examine CSA survivors and assess whether the pattern of their current sexual behavior is addictive or promiscuous. They, therefore, are not directly investigating the prevalence of CSA among addicts, the more pertinent question from an etiological perspective.

Courtois (1979) reported that 80% of her nonclinical sample of former incest victims reported sexual problems, including a compulsive desire for sex. Herman (1981) indicated that 35% of incest survivors in her sample reported promiscuity, and that some survivors employed specific sexual behaviors as a means of securing affection and attention. Tsai, Feldman-Summers, and Edgar (1979) found a difference between sexual abuse survivors seeking therapy and clinical controls with no CSA history, with survivors reporting a greater number of sexual partners. Controlling for gender, age, marital status, and sexual orientation, the investigators found that 43% of the survivors seeking therapy reported 15 or more sexual partners, compared to 9% of the clinical controls. Defining promiscuity as "indiscriminate sexual acting out motivated primarily by non-sexual needs," DeYoung (1982, p. 60) found that 15% of her sample of women incest survivors reported having engaged in promiscuous behavior.

In the one study that examined subjects suffering from sexual addiction (Carnes, 1991), 82% of a sample of 233 men and 57 women in treatment for sexual addiction reported histories of CSA. Unfortunately, for several reasons it is difficult to assess the validity and meaning of this figure. The study itself is described in a book published for a popular, rather than professional, audience. There is minimal explanation of the methodology employed, and no citation is provided to direct the reader to a more extensive account of the study elsewhere. Carnes (1991) does state, however, that the participants who were recruited were those in "advanced recovery" (p. 109). As a rationale for this, he states that the data, otherwise, may have been distorted by denial of having experienced CSA. However, this approach raises other questions about the accuracy of the findings. If the treatment staff believed that CSA is a common precursor of sexual addiction, and one that is often denied, participants who were not subjected to CSA may have been convinced by therapists during the course of their treatment that they had been.

Other authors pose intriguing conjectures about the possible connection between sexual addiction and CSA. McCarthy (1994) suggests that the desire to control the behavior of others can be an after-effect of CSA. From this perspective, it appears highly conceivable to us that sex can be used by survivors as a means of controlling

others, or taking back the control lost when they were overpowered sexually as children. Since sex was learned as one way, and perhaps the only way, to control their environment as children, it is easy to understand how survivors would employ sexuality as a means to exert interpersonal control as adults. Timms and Conners (1992) argue that sexual promiscuity, due to the blurring of sexual boundaries, is one possible consequence of CSA. They claim, based upon clinical observation, that many cases of adult male homosexual promiscuity are related to incidences of CSA by a male perpetrator. They further contend that "promiscuous behavior is an unconscious attempt to control the emotions associated with the original sexual abuse and thus, symbolically, to achieve mastery over the abuser" (p. 21). However, they stop at that assertion, failing to provide an explicit account of how they believe excessive sexual activity accomplishes or is anticipated by the survivors to achieve these ends.

Horowitz (1976, cited in Schwartz, 1992) argues that the natural result of severe trauma is repetition in the form of flashbacks, behavioral reenactments, and other forms of intrusive symptomatology. If sexually addictive behaviors were learned through traumatic experiences, such as CSA, and the acting out is a recapitulation of this trauma, this raises the possibility that inadequately controlled sexual behaviors constitute a variant of the intrusive symptoms of posttraumatic stress disorder (PTSD) rather than an addiction, compulsion, or impulse control disorder. Schwartz (1992), extrapolating from the writings of van der Kolk (1984) on the biological concomitants of psychological trauma, argues that victims of CSA reenact the trauma; the reenactment becomes addictive because the victim experiences a "high" from these behaviors. He hypothesizes that traumatic experiences and their recapitulation may trigger the release of anesthetizing biochemical substances. This proposed connection between sexual promiscuity, CSA, and PTSD has been much more widely recognized in the CSA literature (e.g., Allers & Benjack, 1991; Allers, Benjack, White, & Rousey, 1993; Browne & Finkelhor, 1986; Timms & Conners, 1992; van der Kolk, 1989) than in writings on sexual addiction. The concept of sexual promiscuity and other forms of uncontrolled sexual behavior as constituting manifestations of sexual traumatization may lead to a better understanding of both sexual promiscuity and sexual addiction among survivors of sexual abuse. However, it will be necessary to also study sexual addicts with no history of CSA to develop a more complete understanding of the possible etiological pathways to sexually addictive patterns of behavior.

TREATMENT ISSUES

Treatment of sexual addiction was pioneered by Carnes (1983), who supported the adoption of a 12-step program modified to specifically address uncontrolled sexual behavior. Since then, additional authors have endorsed this approach (Earle & Crow, 1990; Pincu, 1989; Quadland, 1985). Others have advocated group therapy (Goodman, 1992; Pincu, 1989; Quadland, 1985; Schwartz & Brasted, 1985) or pharmacological intervention (Kafka & Prentky, 1992; Stein et al., 1992) as alternative treatment strategies. However, we have only found three published empirical evaluations of efficacy of treatment for sexual addiction, one of group therapy (Quadland, 1985) and two of pharmacological intervention (Kafka & Prentky, 1992; Stein et al., 1992).

Quadland (1985) compared a group of 30 homosexual and bisexual men who presented for treatment of sexual compulsivity with 30 men in therapy for reasons other than sexual problems. The control group was matched for sexual orientation, age,

and socioeconomic status. He sought to answer two research questions. The first of these was, "Do gay and bisexual men who identify themselves as sexually compulsive . . . differ from a control group of men who seek psychotherapy but not with a primary presenting problem of sexual compulsivity, dysfunction, or inhibition?" (p. 124).

Utilizing the Brief Symptom Inventory (Derogatis & Melisaratos, 1983), the author found no significant differences between the two groups. In terms of sexual behavior, however, Quadland (1985) found several significant differences. The sexually compulsive individuals were found to have had fewer long-term (defined as at least 6 months in duration) relationships and more sexual partners per month over the previous 5 years, during their most sexually active year, and during the previous 6 months. They also had more frequently engaged in sex in a public setting and used alcohol or drugs in conjunction with sex more often than the control group. Additionally, based upon a Likert scale of 1 to 5 (never to always), the sexually compulsive individuals reported a lower degree of positive feelings (e.g., loving, relaxed) prior to having sex than did controls.

Second, Quadland (1985) asked, "What is the effect of group psychotherapy treatment for sexual compulsivity on the sexual behavior of group participants?" (p. 124). The goal of the group was to gain control over sexual behavior, with a focus on understanding the needs behind the sexual addiction and changing the individual's behavior. Group members were encouraged to exchange phone numbers and to contact another member as an alternative to seeking out sex. The group members rotated over a 2-year period with an average length of participation of 20 weeks.

Post-testing 6 months after the end of group yielded significant changes on several dimensions of the participants' sexual behavior. First, participants reported a drop in number of different sexual partners in the previous 3 months, averaging 11.5 per month at pretest and 3.3 at posttest. Second, the reported percentage of sexual activity consisting of one time sexual encounters decreased from a mean of 82.3 to 19.6. Third, the proportion of the sample reporting engaging in sexual activity in public fell from 62.3 to 16.1.

Kafka and Prentky (1992) propose a medical explanation for sexual addiction. They classify these behaviors as paraphilic, and assert that such behaviors are appropriately categorized as impulse control disorders. The treatment utilized for their study consisted of the administration of fluoxetene, based on the rationale that sexual addictions are associated with depression, compulsions, impulsivity, and disinhibited aggression, and this medication has been used to treat these symptoms. A baseline of sexually addictive behaviors was established, using the Sexual Outlet Inventory (Kafka, 1991, cited in Kafka & Prentky, 1992) for all participants prior to a 12-week treatment period. The authors report a significant decrease in several aspects of the addiction, including masturbation, other sexual activities, intensity of desire, and total time spent in sexual activity. Unfortunately, many design problems exist with this study. First of all, no control group was utilized. The investigators themselves state that this "raises the possibility that the apparent therapeutic benefit could be related to non drug factors" (p. 356), since some participants received psychotherapy for sexual addiction either prior to or during the study. Second, no placebo control was utilized, so anticipatory effects of treatment could not be measured. Finally, the instrument used to measure conventional and unconventional sexual behavior had not been previously validated.

Similarly, Stein et al. (1992) reviewed the utilization of fluoxetine and other serotonin reuptake blockers in the treatment of paraphilias and nonparaphilic sexual addiction. They hypothesized the response of these disorders to the medication would be similar to that of OCD. The sexual addiction group consisted of five patients with

symptoms including compulsive masturbation, promiscuous encounters, persistent thoughts about erections and ejaculation, and sexual encounters exclusively with prostitutes. Treatment ranged from 6 weeks to 12 months.

Results of treatment were completed by the treating clinician utilizing a Likert scale, ranging from 1 to 7, with 1 representing marked improvement, 7 marked worsening, and 4 no change in symptomatology. Of the five sexually addicted patients, three showed no change in their symptom presentation and two showed moderate improvement. Of the three with no change, one actually worsened prior to returning to baseline. The authors discussed some side effects of the medications, including anorgasmia and delayed ejaculation, which could have conceivably resulted in decreased sexual behavior, although there was no control for these side effects. Additionally, no statistical measurement was reported. This and the small sample size seriously call into question the meaning and generalizability of the results.

Other authors (Goodman, 1992; Schwartz & Brasted, 1985) propose treatment protocols without providing empirical evidence for the efficacy of their approach. Schwartz and Brasted (1985) describe a detailed multistage treatment protocol. The first stage involves stopping the undesirable sexual activity through the use of aversive behavioral techniques, such as covert sensitization and fantasy satiation. They contend that antiandrogens or tranquilizers can assist the client in reaching this initial goal. The next stage is termed *opening the channel* (p. 107) because it entails discontinuation of rationalization and denial, admission of the problem, and a promise to keep no secrets from the therapists and group members. The authors contend that "Group therapy is useful for boosting self-esteem and sanctioning normal manifestations of sexuality, such as masturbation" (p. 107).

Once the client contracts to stop acting out for at least 6 months, the next stage is initiated. It consists of introducing the client to techniques such as relaxation, exercise, problem solving, and self-assertiveness, aimed at counteracting the agitation and stress that initially provoke sexual acting-out. The subsequent stage employs cognitive-behavioral intervention to reverse the client's helplessness through "behavioral suggestions" (p. 107). Clients are then taught to identify negative emotions as signals for problem solving and assertive action. The final stage is devoted to the resolution of any remaining problems the client may have that interfere with establishing a primary sexual relationship. Treatment is considered complete when the client is able to "establish a healthy, committed primary relationship and a network of secondary relationships" (p. 107).

Goodman (1992) asserts that both compulsion and dependence should be focused on in treatment. Although he contends that the term *addiction* best describes the phenomenon in question, he asserts that it encompasses two sets of implications. First, sexual addiction involves compulsion, or motivation to avoid an unpleasant internal state, and dependence, or a drive to achieve a pleasurable internal state. Based on this reasoning, he recommends pharmacotherapy, such as antidepressants and mood stabilizers, or psychotherapy to address these factors. He proposes that individual therapy, 12-step groups, and other supportive or therapeutic groups can assist in helping the client fulfill the needs currently met by the sexual addiction.

The second implication, according to Goodman (1992), involves the relationship between sexual addiction and other addictions. Because the basic process underlying all addictions is the same, treatment, he insists, should follow the same model employed to treat substance dependence. In other words, treatment of sexual addiction should address the client's loss of control and continuation of the behavior despite

harmful consequences. In contrast with therapy for substance dependence, however, the treatment goal is not abstinence, but self-control of previously addictive behaviors.

DISCUSSION

The possible existence of a syndrome consisting of uncontrolled sexual behavior is by no means an inconsequential issue. Dire consequences of such a behavior pattern, such as contracting and spreading HIV/AIDS, make it imperative that the helping professional seriously consider and investigate the possibility that reckless sexual activity may constitute a form of psychopathology. If sexual addiction exists, the benefits to both the individual and society of devising a demonstrably effective treatment protocol could be enormous. However, even fundamental research investigating whether sexual addiction constitutes a reliably identifiable syndrome is yet to be conducted.

A considerable degree of consensus exists in the literature on the symptomatology and course of sexual addiction. Most agree that the disorder is both progressive and cyclical. In other words, the symptoms are seen as progressing in terms of both level of distress and dangerousness and intensity of the sexual behaviors performed. Unfortunately, in the absence of basic empirical data, it is difficult to know to what degree agreement across authors reflects a convergence of clinical observations, and to what extent it represents uncritical acceptance of the assertions about sexual addiction originally presented by Carnes (1983).

On the other hand, there is considerable divergence of opinion among authors about whether to conceptualize and designate this phenomenon as an addictive, obsessive-compulsive, or impulse control disorder. Each perspective is grounded predominantly in clinical experience. Each viewpoint presents a defensible argument that sexual addiction conforms to the current *DSM* criteria for a different particular diagnostic category. Our own clinical observations suggest that there are often multiple functions of and reasons for persistent, uncontrolled sexual activity. Instead of determining which perspective is correct, therefore, the truth may be that each of them accurately accounts for a subgroup of cases. In any event, it is unlikely that much will be settled at this point by further debate. Instead, the ability of various conceptual positions to account for these patterns of behavior needs to be assessed by well-controlled empirical research.

Although few studies have been conducted to examine treatment outcome for sexual addiction, those that do report positive findings. However, they generally have in common the employment of minimal methodological controls. Considering the diversity of treatment approaches advocated in the literature (e.g., drug therapy, group therapy, individual therapy, and 12-step groups), comparing the efficacy of various treatment protocols will be essential in assisting therapists in determining which approach is best suited for a particular client.

The area of sexual addiction has reached a point in its conceptual development that is likely to rapidly culminate in stagnation. The literature on this topic consists largely of theory and conjecture based almost entirely on clinical observation rather than on research findings. Only with the execution of controlled empirical research on etiology, symptom patterns, course, related difficulties and their consequences, and treatment, is our knowledge base in this area likely to substantially move forward. A crucial initial step in this process will be to evaluate the validity of the construct that uncontrolled sexual behavior constitutes a cohesive syndrome. This will in turn require

that specific, measurable criteria for identifying such a syndrome be established and empirically assessed. Based upon the above review, it seems clear that aggressive and extensive empirical exploration of the phenomena that are alleged to constitute sexual addiction is urgently needed if we are to ultimately design effective interventions for those suffering from its potentially life-threatening consequences.

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