Addictive Sexuality: Diagnostic Controversies

By Stefanie Carnes, PhD, LMFT, CSAT-S

As of this writing, there is no "official" diagnosis for sexual addiction in the United States. This despite a painstakingly researched and brilliantly argued 2010 position paper, commissioned by the American Psychiatric Association (APA) and written by Harvard's Dr. Martin

Kafka, recommending hypersexual disorder (as Kafka prefers to label the issue) for inclusion in APA's diagnostic bible, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). In his position paper, Kafka examined the then-extant research and concluded, clearly and definitively, that sexual addiction is a very real and treatable disorder. He also proposed a set of diagnostic criteria. Kafka wrote:

> The data reviewed from these varying theoretical perspectives is compatible with the formulation that hypersexual disorder is a sexual desire disorder characterized by an increased frequency and intensity of sexually motivated fantasies, arousal, urges, and enacted behavior in association with an impulsivity component — a maladaptive behavioral response with adverse consequences. ... Hypersexual disorder is associated with increased time engaging in sexual fantasies and behaviors (sexual preoccupation/sexual obsession) and a significant degree of volitional impairment or "loss of control" characterized as disinhibition, impulsivity, compulsivity, or behavioral addiction. ... [Hypersexual disorder] can be accompanied by both clinically significant personal distress and social and medical morbidity.[1]

In simpler terms, after considering literally hundreds of peer-reviewed studies and articles, one is left to conclude that sexual addiction, except for the fact that the "drug of choice" is sex rather than an addictive substance, develops and manifests in the same basic ways, with the same basic consequences, as alcoholism, drug addiction, and all other addictive behaviors.

Despite this significant evidence, the APA chose to not include hypersexual disorder in the DSM-5. Moreover, they refused to list it as a condition worthy of further study. This, of course, left hundreds of sexual addiction treatment specialists and countless thousands of sex addicts scratching their heads and asking, "What gives?"

With or without an official diagnosis, of course, many sex addicts still (eventually) self-assess as sexually addicted and seek treatment based on this knowledge. However, when they seek insurance-funded clinical assistance they can be stonewalled — because insurance companies usually refuse to fund treatments not backed a DSM-5 diagnosis. Thus, sex addicts and the clinicians who treat them often find themselves working around the APA's decision, usually by listing a symptomatic or co-occurring issue as the primary reason for treatment. Many sex addicts also present with depression, anxiety, eating disorders, and/or a cross or co-occurring addiction — all of which are "officially diagnosable" DSM disorders. However, this type of partially accurate diagnosis is less than ideal, and neither therapists nor addicts should be forced to play this little game.

> NOTE: Some psychotherapists think it is possible to diagnose sexual addiction more directly via the DSM-5. For instance, Dr. Richard Krueger[2] of Columbia University and the New York State Psychiatric Institute suggests that a pair of generalized disorders, Other Specified Sexual Dysfunction (302.79) and Unspecified Sexual Dysfunction (302.70), may work, even though the criteria are largely unrelated to the diagnostic criteria used to identify sexual addiction.[3]

In addition to issues with insurance funding, without an official diagnosis sexual addiction can be misunderstood and misrepresented by certain clinicians. Some seem to think that without an official diagnosis, sexual addiction does not exist. However, this is akin to saying there were no alcoholics prior to the 1970s, when the APA finally adopted an official diagnosis. Even worse, as we saw with alcoholism prior to its "legitimization" by the APA, sex addicts are sometimes stigmatized and written off as immoral people behaving badly, rather than people suffering from a treatable psychiatric condition.

So why did the APA choose to exclude sexual addiction from the DSM-5? The only explanation ever given is the "lack of supportive research." This rationale is provided in the introduction to the Addictive Disorders section, which states:

> [Groups] of repetitive behaviors, which some term *behavioral addictions,* with such subcategories as "sex addiction," "exercise addiction," or "shopping addiction," are not included because at this time there is insufficient peer-reviewed evidence to establish the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders.[4]

However, as Kafka notes in his position paper, there is more than enough evidence for the APA to officially recognize sexual addiction. In fact, many of the disorders currently included in the DSM-5 (particularly the sex-related disorders) have significantly less supportive evidence. About this, Kafka writes, "The number of cases of hypersexual disorder reported in the peer reviewed journals greatly exceeds the number of cases of some of the codified paraphilic disorders, such as fetishism and frotteurism."[5]

Sadly, this is not the first time the APA has ignored both research and clinical realities when it comes to addictions. In fact, as mentioned above, alcoholism was a generally accepted disorder for *decades* before the APA finally relented and provided an official diagnosis. With sexual addiction, we are seeing a similar progression. Worldwide, for several decades, people all over the world have self-identified as sexually addicted, seeking both clinical and 12-step recovery as available. Meanwhile, countless studies confirm the existence of and our ability to both diagnose and successfully treat sexual addiction. Again, despite this evidence, the APA has been unwilling to change its position.

In addition to the hundreds of studies analyzed by Kafka, dozens of more recent studies also support sexual addiction. For example, a group of researchers led by UCLA's Rory Reid conducted a field study testing the clinical utility, reliability, and validity of Kafka's proposed diagnostic criteria, as outlined in his position paper, and concluded that his proposed benchmarks (which coincide nicely with the criteria generally in use by properly trained and certified sex addiction therapists[6]) are both accurate and well thought out—more so, in fact, that most other sets of DSM diagnostic criteria.[7]

Other research has considered the neuroscience of sexual addiction. One significant study looked at "cue reactivity," a hallmark of addiction disorders. (For example, research tells us that when a cocaine addict sees a line of cocaine, his or her brain "lights up" in a very specific way, and that response is quite different than in the brain of a non-addict.[8]) The sex addiction cue reactivity study, conducted at the University of Cambridge by Dr. Valerie Voon, a leading authority on addiction in the brain, produced parallel results: in self-identified sex addicts (but not in a non-addicted control group) neurobiological cue reactivity to sexual stimuli mirrors that of drug addicts when exposed to drug-related stimuli.[9]

A second neurobiological study examined "attentional bias," another hallmark of addiction disorders. Here, the research team, again led by Dr. Voon, used attention-distraction techniques — specific tasks measuring the degree to which addicts will focus their attention on an addiction-related image as opposed to a neutral image. Once again, there were significant parallels between self-identified sex addicts and drug addicts.[10]

Additionally, researchers led by Dr. Simone Kuhn from the Max Planck Institute in Berlin have linked compulsive sexual behaviors to changes in brain structure.[11] In short, they found that compulsive viewing of pornography correlates with a reduction in gray matter in the brain's rewards circuitry. This means that porn addicts, over time, tend to develop a sluggish or numbed pleasure response. The study found that "regular consumption of pornography more or less wears out your reward system," and that "subjects with a high porn consumption need increasing stimulation to receive the same amount of reward." This, of course, mirrors the tolerance and escalation that we commonly see with substance use disorders.

Other post-Kafka sex addiction research finds parallels between sexual addiction and other forms of addiction regarding: characteristics and motivations of addicts,[12] diagnosis,[13] consequences,[14] and desire for clinical assistance,[15] among other issues.

Individually, of course, none of these studies definitively proves the existence of sexual addiction, just as no single study proves the existence of alcoholism or drug addiction. However, taken together, along with the hundreds of studies Kafka analyzed, we start to see a pattern. And that pattern tells us that sexual addiction is a very real disorder.

Regardless, we have no official diagnosis. Perhaps the issue is not, as the APA intimates, a lack of research.

One fairly obvious sticking point with many sex addiction critics involves terminology. Over the years, numerous labels have been proposed, including (but by no means limited to) the following: sexual addiction,[16] impulsive sexual behavior,[17] sexual compulsion,[18] and hypersexual disorder.[19] In some ways, this mostly spurious nomenclature issue stems from the fact that some people seem to think the word "addiction" is shaming and

counterproductive. The APA, for instance, almost completely removed that term from the DSM-5, rebranding alcoholism and drug addiction as *substance use disorders* and gambling addiction as *gambling disorder*. However, most of the people who struggle with out-of-control, life-destroying behaviors choose to self-identify as addicted and to seek help accordingly. One could posit that this APA alteration may be why Kafka opted for the term "hypersexual disorder" rather than other, more commonly accepted terminology.

In a recent issue of the Journal of Addiction Medicine, Dr. Patrick Carnes compares the various conceptualizations of sexual addiction.[20] (See chart below.)

Interestingly, the only real difference between the conceptualizations is that researchers using the addiction model sometimes include tolerance, escalation, and withdrawal among their criteria, while the others do not. More importantly, all of the conceptualizations mesh with language adopted in 2011 by the American Society of Addiction Medicine (developed over the course of four years with input from more than eighty neuroscientists). ASAM writes:

> Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction also affects neurotransmission and interactions between cortical and hippocampal circuits and brain reward structures, such that the memory of previous exposures to rewards (such as food, sex, alcohol and other drugs) leads to a biological and behavioral engagement in addictive behaviors.[21]

With this statement, the scientists at ASAM drew a line in the sand — clearly stating that food, sex, and other behaviors can be addictive. Despite this declaration and the abundance of neuroscientific research to support it, the APA nevertheless refuses to accept the concept of sexual addiction.

Another of the more common anti-sex addiction arguments is that sex addiction treatment is shaming, sex negative, and based on morality rather than sound scientific principles. In reality, nothing could be further from the truth. Properly trained and certified sex addiction therapists do not pathologize consensual and legal sexual activity of any kind. Qualified sex addiction therapists are not the sex police, nor do they want to be the sex police. In fact, as a rule, they are wonderfully sex positive, encouraging any and all sexual activities, as long as they are not obsessive, out-of-control, and creating problems.

A similar concern centers on the fact that a few unethical religious/moralistic clinicians offer reparative (gay conversion) therapy but call it sex addiction therapy — even though their "treatment" has nothing whatsoever to do with sexual addiction. This approach is NEVER condoned by properly trained and credentialed sex addiction therapists. In fact, the largest training organization for certified sex addiction therapists (CSATs) has a clear guideline in its ethics policy stating that CSATs may not, under any circumstances, attempt reparative therapy. From CSATs perspective, reparative therapy is not only ineffective,[22] its unethical.

Rather than being moralistic and sex negative, true sex addiction treatment, as provided by properly trained and certified sexual addiction therapists, is sex positive in every respect. To this end, each client creates a plan for sexual health that is tailored to his or her individual background, goals, and sexual arousal template. As with eating disorders treatment, where the endgame is a healthy and life-affirming relationship with food, sex addicts

Criteria	**Hypersexuality: Theory of Dependence** (Orford, 1978, p. 308)	**Sex Addiction** (Carnes, 1983, 191)	**Sexual Addiction** (Goodman, 1998, pp. 233-234)	**Hypersexual Disorder** (Stein et al., 2001, pp. 1592-1593)	**Nonparaphilic Compulsive Sexual Disorder** (Coleman, 2003)	**Sex Addiction** (Carnes, 2005)	**Hypersexual Disorder** (Kafka, 2010)
Recurrent failure (pattern) to resist sexual impulses to engage in specific sexual behavior	X	X	X			X	X
Frequent engaging in those behaviors to a greater extent		X	X			X	X
Persistent desire or unsuccessful efforts to stop, to reduce, or to control behaviors	X	X	X	X		X	
Inordinate amount of time spent in obtaining sex, being sexual, or recovery from sexual experiences	X		X			X	X
Preoccupation with the behavior or preparatory activities	X			X	X	X	X
Frequent engaging in the behavior when expected to fulfill occupational, domestic, or social obligations			X	X	X	X	X
Continuation of behavior despite knowledge of having persistent or recurring social, financial, psychological, or physical problem that is caused or exacerbated by the behavior	X	X	X	X	X	X	X
Need to increase the intensity, frequency, number or risk of behaviors to achieve the desired effect or diminished effect with continued behaviors at the same level of intensity		X	X			X	
Giving up or limiting social, occupational, or recreational activities because of their behavior		X	X			X	X
Distress, anxiety or restlessness, or irritability if unable to engage in the behavior	X		X			X	

focus on the development of a healthy and life-affirming relationship with sex, however they might define that. As such, every recovering sex addict, working in conjunction with his or her therapist, creates a unique plan for sexual sobriety, with non-compulsive sex positive behaviors being a "go," and only destructive sexual behaviors being a "no."

In short, properly trained sex addiction therapists are sex positive and supportive of all sexual orientations and behaviors as long as the related behaviors are consensual, legal, and do not cause problems for the addict. That said, certified sex addiction specialists recognize that not all sexual behaviors are benign, non-destructive, and non-distressing. Some sex can become compulsive, and over time these behaviors can and often do result in negative life consequences. Ignoring this reality makes it harder for the individuals who are suffering to reach out for and find the assistance they desperately need. Instead of getting help, these struggling sex addicts feel stigmatized, ashamed, abnormal, and hopeless. This shaming will continue to varying degrees until the APA relents and reverses its outdated stance, legitimizing sexual addiction in the DSM.

Is the APA likely to amend the DSM and officially recognize sexual addiction in the near future? Most likely not. After all, when it comes to making significant changes to the ways in which clinicians view psychiatric disorders, it looks like the APA will be the last to arrive at the party. That said, the organization will eventually have to reverse its position because the scientific evidence in favor of sexual addiction is rapidly mounting. Until the APA yields, however, we cannot hope to see any meaningful change. Sex addicts hoping to heal will still seek sex addiction treatment, insurance companies will refuse to pay for it, and sex addiction clinicians will continue to help these addicts as best they can.

ENDNOTES

[1] Kafka, M. (2010). Hypersexual disorder: A proposed diagnosis for DSM-V. *Archives of sexual behavior, 39*(2), 377-400.

[2] Dr. Krueger served as a member of the American Psychiatric Association's Sexual and Gender Identity Disorders Workgroup, and he is a member of the World Health Organization's Sexual Health and Disorders Committee, charged with making recommendations for changes to the next version of the ICD (the ICD-11), scheduled for release in 2018.

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Chart: From JAMA article

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