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THE DEBATE:
SEXUAL ADDICTION AND COMPULSION

JUNE/JULY 2003

SIECUS

R E P O R T

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TAKING OFF TO EXPLORE LIFE'S POSSIBILITIES

Mac Edwards

This is my last *SIECUS Report* column. After almost eight years as your editor, I have decided to take off with my partner Reggie to explore life's many possibilities. Or, as *The New York Times* said recently about people of my generation (50-something): to *re-wire*—not to *retire*. We are both embracing this change with a full sense of optimism and possibility.

As I thought about writing this last column, I realized that a lot has changed in terms of sexuality education and sexual health since I joined SIECUS as its editor in October 1995. For one, while abstinence-only-until-marriage programs might have been taking place quietly in a few communities, they were far from the federal program and national movement that they are today. The phrase was rarely uttered. For another, Bill Clinton had not yet met Monica Lewinsky, and Americans were not yet used to hearing daily discussions on television news programs about oral sex and masturbation.

The first *SIECUS Report* article I edited was a discussion by Dr. Eva Goldfarb on the pros and cons of mixed-gender sexuality education classes. That debate seems pretty innocuous in light of the issues facing sexuality educators today.

THE PAST

In the interim, I feel that I have edited some groundbreaking articles that have contributed to the literature in our field. One of my favorite parts of this job has been deciding what topics should be covered in the *SIECUS Report*. I remember our staff discussing the possibility of writing about lesbian, gay, bisexual, transgender, and questioning young people; sexual pleasure; religion and sexuality; and the mass media and sexuality.

Many of the issues I edited started with discussions with other colleagues in the field. For example, a few years ago psychologist Steve Brown of the Traumatic Stress Institute in South Windsor, CT, called me to suggest that we develop a *SIECUS Report* on sexual abuse. He contributed many hours contacting writers and working with me to make our "Sexual Abuse" issue, which I consider one of our very best (indeed it is our longest).

Another important issue, "The Construction of Gender," came about in a similar manner when trainer and consultant Lis Maurer, of Ithaca, NY, contacted me. Lis worked with me for many months to develop specific topics and contact

writers for an issue that took a very close look at some unresolved issues around gender.

Turning these discussions into high-quality issues of the journal was challenging and exciting. I am proud that in some small way, I was able to shape discussions in the field and bring attention to these important topics.

THE PRESENT

This issue, however, had a slightly different birth, and it seems fitting for it to be my farewell. The idea for "The Debate: Sexual Addiction and Compulsion" came from me.

Last year, at the annual meeting of the American Association of Sex Educators, Counselors, and Therapists, I attended a roundtable conducted by Dr. Eli Coleman of the University of Minnesota. I was fascinated by the ongoing debate about compulsive sexual behavior and whether it could be considered an addiction. I spoke to Dr. Coleman immediately about bringing information on this topic to *SIECUS Report* readers.

With his help, we have brought together articles from key experts in the field that represent extremely different points of view. Dennis Sugrue provides a good overview of the debate; Patrick Carnes writes about sexual addiction as being akin to addictions to alcohol or drugs; Marty Klein counters, suggesting that sexual addiction is an oversimplified and potentially harmful classification; and Eli Coleman explains the concept of compulsive sexual behavior as a potential middle ground. In addition, Nancy Raymond discusses new treatment options.

I feel that by including all sides of this debate, this issue gives readers a comprehensive view of the topic and allows them to weigh various theories and opinions. I am proud to end my career at SIECUS with such a thought-provoking issue.

THE FUTURE

I will always care about SIECUS and its work. It has meant a great deal to me, and it has helped me grow as a professional and as a person.

I look forward to reading future issues of the *SIECUS Report*. And who knows, I might even submit an article for publication sometime in the near future.

THE VALUE OF AN ONGOING DEBATE

Tamara Kreinin, M.H.S.A.

As I was researching this column, I came across a *SIECUS Report* from almost two decades ago. In 1986, SIECUS devoted an issue of this journal to the topic of sexual addiction and compulsion. The issue focused on the ongoing debate and featured different views from leaders in the field, including Eli Coleman and Patrick Carnes.

Writing this nearly 20 years later, I would love to tell you that the debate has been resolved. In my ideal world, years of well-funded, scientific research would have helped professionals in the fields of sexology, sex therapy, and medicine come to mutually agreeable conclusions about compulsive sexual behavior, including terminology, causes, and, most importantly, treatments.

Instead, I present you with an issue dedicated to the debate surrounding sexual addiction and compulsive sexual behavior, featuring different views on the topic from Eli Coleman and Patrick Carnes, as well as other leaders in the field such as Marty Klein and Dennis Sugrue.

THE IMPORTANCE OF DISCOURSE AND DEBATE

This is not to say that we have made no progress in the intervening years. To the contrary, in reading these articles it has become clear to me that the last two decades have provided us with new research, additional clinical experience, fresh ideas, and a more informed and refined debate.

In fact, I am excited to share this issue with readers precisely because the topic remains unresolved. SIECUS has always been a strong believer in discourse, debate, and discussion. Regardless of the topic, it is only through open and honest debate that we move forward. Debates such as this force us to think critically, evaluate the positions we have held, examine the viewpoints of others, and ultimately clarify our own beliefs. I am pleased that the *SIECUS Report* can be the forum for this kind of intellectual pursuit.

However, there is another important reason that we chose to revisit this topic after so many years: people.

COMPASSION FOR INDIVIDUALS

While much of this debate, and most of the articles you will read, focus on theories, we need to remember that in the end this topic is about individuals. Specifically, it is about

individuals whose sexual behavior is not hurting anyone else but has become problematic for them.

As professionals, we walk a fine line. On the one hand, we need to avoid labeling people or sexual behaviors as problematic simply because they differ from our personal values or accepted definitions of “normal.”

SIECUS believes that responsible sexual relationships are consensual, nonexploitative, honest, pleasurable, and protected against unintended pregnancies and sexually transmitted diseases. Given these parameters, all adults have the right to make their own decisions about their sexual behavior. It is not our role as professionals to judge how much sexual activity is “too much.”

At the same time, we need to recognize that there are people whose sexual behavior has become obsessive, compulsive, or excessive to the point that it is causing them distress and interfering with their lives. We need to ensure that these people receive our compassion and our help.

I think that it is important that this debate continues to evolve through research, clinical practice, and discourse. In the meantime, we need to ensure that we continue to use all available resources and theories to help those people for whom this has become an issue.

A BITTERSWEET GOODBYE

As you will learn from his column, this marks the last issue for SIECUS’ long-time editor Mac Edwards. After nearly eight years in this position, Mac has decided to retire to Florida with his partner and take up entirely different pursuits. He has discussed working with flowers or brushing up on his French so that he can begin to teach the language to others.

Mac recently realized that in his time here he had edited 48 issues of the *SIECUS Report*, totaling way over 1,000 pages. In addition to this journal, Mac was involved in every publication SIECUS produced in recent years, from annual reports and newsletters to policy pamphlets and education manuals. No matter how good the first draft was, Mac always made the final product that much better.

Mac’s work at SIECUS will continue to have an impact even as he moves on. We will miss him terribly but wish him the best of luck and are excited to see what he does next.

GIVING PROBLEMATIC SEXUAL BEHAVIOR THE SERIOUS ATTENTION IT REQUIRES

Dennis P. Sugrue, Ph.D.

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Ann Arbor, MI

Few topics in the sexology field have galvanized people into opposing camps as stridently as the topics of sex addiction and sexual compulsivity. They are lightning rods in a 20-year-old controversy about the nature and origin of problematic high-frequency sexual behavior.

Traditionally, sexologists have balked at the notion of sexual addiction. They have dismissed it as a sex-negative paradigm serving the conservative right. Yet, clearly, anyone who has worked with clinical populations encounters men and women who struggle with sexual impulses—often engaging in cycles of behavior that swirl further and further out of control.

Take the case of a woman named Charlene, who is 32 years old and has been married for 15 years. She is spending increasing amounts of time in a cyber chat room. It started out of curiosity, but recently she has been going to bed later and later because of her chatting, flirting, and occasional masturbating with an online partner. She feels guilty when she crawls into bed next to her sleeping husband. “No more,” she vows each night. But the next day she finds herself marking time until she can log on again.

Does Charlene have a sexual addiction? Depending on your theoretical orientation, you may answer yes or no. Does Charlene have a problem—a problem likely requiring careful assessment and possible intervention? Probably yes.

Do we know much about the incidence, demographics, or co-morbidity of this type of problem? Unfortunately, we do not, because we do not have universally accepted diagnostic criteria or even terminology for describing it. The lack of well-defined diagnostic criteria represents a major barrier to conducting clinical research and developing effective treatment for this problem. The American Psychiatric Association’s (APA’s) *Diagnostic and Statistical Manual of Mental*

Disorders (DSM-IV) virtually ignores problematic hyper-sexuality, offering nothing more than an ineffectual label, Sexual Disorder NOS (Not Otherwise Specified).

In the next few years, the APA will release the *DSM-V*. Inclusion of this problem in *DSM-V* can have important implications ranging from insurance coverage for treatment to increased availability of research funding. Inclusion will help to insure that legitimate sexual problems are identified and, equally important, that benign sexual behavior is not pathologized.

But inclusion in *DSM-V* will not be easy because the APA will only accept diagnostic criteria that are supported by a substantial body of empirical research. And for research to occur, we need generally accepted definitions and criteria.

Toward that end, an historic meeting took place at Vanderbilt University. Fifty invited participants spent two intense days discussing how to develop terminology and diagnostic criteria for problematic hyper-sexuality. The group was able to move beyond the sticking point of whether we were talking about an addiction, a compulsion, or an impulse disorder.

A strong case was made for relying on descriptive language rather than falling back on theoretical positions such as addiction or compulsion. It was evident that people were making a serious commitment to find language

and definitions that all parties could accept and work with.

Much remains to be done, but, finally, common ground is being staked out for sexologists and other medical and mental health professionals to share. The days of heated rhetoric appear to be coming to an end. We may finally give problematic sexual behavior the serious attention it requires—unencumbered by politics, personalities, or dogma.

Based on: *AASECT, President Column Dr. Dennis Sugrue, Contemporary Sexuality, 2002*

*Much remains to be done, but, finally,
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UNDERSTANDING SEXUAL ADDICTION

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During the past three decades, professionals have acknowledged that some people use sex to manage their internal distress. These people are similar to compulsive gamblers, compulsive overeaters, or alcoholics in that they are not able to contain their impulses—and with destructive results.

DEFINITION

To facilitate classification and understanding of psychological disorders, mental health professionals rely on the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association and now in its fourth edition.

Each edition of this book represents a consensus at the time of publication about what constitutes mental disorders. Each subsequent edition has reflected changes in understanding. The *DSM's* system is, therefore, best viewed as a “work in progress” rather than the “bible.”

The term *sexual addiction* does not appear in *DSM-IV*. In fact, the word *addiction* itself does not appear. It condenses the criteria for addictive disorders—such as substance abuse and pathologic gambling—into three elements:

- *Loss of control (compulsivity)*. “There is a persistent desire or unsuccessful efforts to cut down or control substance abuse.” “Has persistent unsuccessful efforts to control, cut back, or stop gambling.”
- *Continuation despite adverse consequences*. “The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance use.” “Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling.”
- *Obsession or preoccupation*. “A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.” “Is preoccupied with gambling.”¹

COMPLEX PROBLEM

Typically, individuals in trouble for their sexual behavior are not candid about whatever incident has come to light, nor are they likely to reveal that the specific behavior actually is a part of a consistent, self-destructive pattern. The nature of this illness causes patients to hide the severity of the problem from others, to delude themselves about their ability to control their behavior, and to minimize their impact on others.

Often some event will precipitate a visit to the primary care provider. Sexual excess of some type will create a physical problem. Sexually transmitted diseases, damage to genitals, unwanted pregnancies: all are among the reasons for such a visit. Most patients will say that the event is a unique situation.

The primary care provider will often treat the physical problem without probing for more information. If, however, there is sexual addiction, the problem will not disappear. A wide range of behaviors can be problematic, including compulsive masturbation, affairs, use of pornography, voyeurism, exhibitionism, sexual harassment, and sex offending.

Health care providers must understand that underneath what appears to be an isolated event may be a more complex pathologic problem with a host of related factors such as the following:

- A high incidence of depression and suicide
- The presence of high-risk and dangerous behaviors including self-harm designed to escalate sexual experiences
- The high probability of other addictive behaviors including alcoholism, drug abuse, and pathologic gambling
- Extreme disruption of the family, including battering, sexual abuse, and financial distress

BEHAVIORS

Clinicians should remember that the discovery of something sexual does not make an addictive illness. A long-term affair, for example, would be a problem for a spouse but would not be a compulsive pattern. Likewise, a person with exploitive or violent behavior does not necessarily have an addictive illness.

I have been gathering data on sexual addiction since 1985. In the process, I have found that sexually addictive behavior clusters into 10 distinct types. Patients often will be active in more than one cluster. That is one of the most important lessons of sexual addiction: Patterns exist among behaviors.

The 10 distinctive types of behaviors are:

- *Fantasy sex*. Arousal depends on sexual possibility. The individual neglects responsibilities to engage in fantasy and/or prepare for the next sexual episode.
- *Seductive role sex*. Arousal is based on conquest and diminishes rapidly after the initial contact. It can be heightened by increasing risk and/or number of partners.

- *Voyeuristic sex.* Visual stimulation is used to escape into an obsessive trance. Arousal may be heightened by masturbation or risk (peeping), or violation of boundaries (voyeuristic rape).
- *Exhibitionistic sex.* The individual attracts attention to the body or its sexual parts. Arousal stems from the shock or the interest of the viewer.
- *Paying for sex.* Arousal is connected to payment for sex and, with time, it actually becomes connected to money itself. Payment creates an entitlement and a sense of power over meeting needs. The arousal starts with “having money” and the search for someone in “the business.”
- *Trading sex.* Arousal is based on gaining control of others by using sex as leverage.
- *Intrusive sex.* Arousal occurs by violating boundaries with no repercussions.
- *Anonymous sex.* Arousal involves no seduction or cost and is immediate. It has no entanglements or obligations associated with it and often is accelerated by unsafe or high-risk environments such as parks and restrooms.
- *Pain-exchange sex.* Arousal is built around specific scenarios or narratives of humiliation and shame.
- *Exploitive sex.* Arousal is based on target “types” of vulnerability. Certain types of vulnerable people (such as clients/patients) become the focus.

In addition, in recent years people have begun to use cybersex in unexpected numbers, and many are finding themselves accessing sex in problematic ways.

Individuals suffering from sexual addiction have found sex on the Internet a natural extension of what they are already doing. They can act out any of the previously mentioned 10 types of sexual behavior on the Internet. They can find sex partners, be voyeuristic, start affairs, and swap partners, among other things.

There are also many individuals who never would have experienced sexual compulsive behavior had it not been for the Internet. Consider this:

- About 200 sex-related Web sites are added each day, and there are more than 100,000 existing sites.
- Sex on the Internet constitutes the third largest economic sector on the Web (software and computers rank first and second), generating one billion dollars annually.
- A total of 65 million unique visitors use free porn sites, and 19 million unique visitors use pay porn sites each month.
- Approximately one percent of Internet users have a severe problem that focuses almost exclusively on cybersex, with major neglect of the rest of their life’s activities.²

SUCCESSFUL TREATMENT

A number of key factors are involved in successful recovery from sexual addiction. They include:

- *A good addiction-oriented primary therapist.* Most successful recoveries involve a relationship with a therapist over a three- to five-year period, the first two years of which are very intense.
- *A 12-step sexual addiction group.* The probability of relapse is extremely high if the addict does not attend meetings.
- *A 12-step program for other addictions.* If the addict has other addictions, a 12-step program is necessary for those as well. A suggestion that makes things easier is to find a sponsor or sponsors who attends all of the same meetings your patient does. This way, there is a consolidation of relationships.
- *Program work, not just attendance.* Completing step work, finding a sponsor, and doing service are all key elements of recovery. Individuals should become actively involved in the program’s activities. In a recent outcome study of an inpatient program for sexual addiction, researchers discovered that only 23 percent actually complete the first nine of the 12 steps in 18 months. However, of those who did, recidivism was rare.³
- *Early family involvement.* Family participation in the patient’s therapy improves the chance for success.
- *Spiritual support.* Addicts report that the spiritual work started in their 12-step communities and continued in various spiritual communities was critical to the changes they needed to make.
- *Exercise along with good nutrition and a healthy lifestyle.* Addicts who reduce their stress, start an exercise program, and eat more healthfully do better in their recovery.

In discussing what had helped them in their recovery, over 190 sex addicts indicated that these treatments were the most helpful (in order from most to least): a higher power (87 percent); couples 12-step group based on sexual addiction (85 percent); a friend’s support (69 percent); individual therapy (65 percent); a celibacy period (64 percent); a sponsor (61 percent); exercise/nutrition (58 percent); a 12-step group based on subjects other than sexual addiction (55 percent); partner support (36 percent); inpatient treatment (35 percent); outpatient group (27 percent); therapy (21 percent); family therapy (11 percent); and after care (hospital) (9 percent).⁴

HEALTHY SEXUALITY

The goal of treatment is healthy sexuality. Some therapists insist on a period of celibacy, which does help to reduce chaos and make patients available for therapy. But recovery from sexual addiction does not mean sexual abstinence.

The objective of treatment is to help individuals develop a healthy, strong sexual life. One of the risks is that the patients may slip to a position of sexual aversion, in which they think all sex is bad. Sexual aversion, or “sexual anorexia,” is simply another variant of sexual compulsive behavior.

Patients will sometimes bounce from one extreme to the other. True recovery involves a clear understanding about abstaining from certain sexual behaviors combined with an active plan for enhancing sexuality.

Recovery from sexual addiction is likened to recovery from eating disorders. Food is a necessary part of life, and recovery from eating disorders requires defining what is healthy eating and what is not. Similarly, the goal of recovery from sexual addiction is learning what is healthy sexuality for the individual.

Healthy sexuality for most sexually addicted individuals involves not only a change in behavior but also an avoidance of fantasizing about behaviors that are unhealthy. Sexual fantasizing can be healthy, particularly for a reasonably healthy couple that uses their increased excitement to move toward rather than away from the partner. However, sexual imagery that is not respectful of other human beings increases objectification, depersonalization, and destructive bonding based on hostility rather than affection. Asking patients about his or her “sobriety” definition and about the content of fantasies provides clues to help with treatment and recovery.

KEEPING UP

To determine how well the patient is doing in establishing a healthy lifestyle, clinicians can ask some simple questions. Does the patient have tools for avoiding relapse during times of hunger, anger, loneliness, and tiredness? Is the patient attending 12-step self-help meetings? If not, what are the obstacles preventing the patient from doing so? What are the patient’s perceptions of what goes on at a

meeting? Does he or she have a sponsor (a person longer in recovery who can guide the newer member)?

Is the patient seeking a counselor or therapist who is knowledgeable in addiction recovery? Is there balance between work and recreation? Is the patient exercising or engaging in any sports? Is the patient actively working to improve his or her relationship with a spouse or significant other? Is the spouse also attending a self-help meeting? These are all indicators to determine if the individual is fully engaged in building a healthier lifestyle.

CONCLUSION

The treatment of sexual addiction has taken a long time to gain recognition and respect as an area of medical specialty.

As with other disorders, such as alcoholism or anorexia, clinicians face many challenges in learning about sexual addiction. Most who take time to learn find patients who are profoundly grateful.

In many ways, the field of sexual addiction lags behind both professional and lay awareness of alcoholism or anorexia. Yet, important strides are being made in both understanding and awareness.

Appreciating the issues and challenges of sexual addiction will help clinicians when their patients’ behaviors cross the line from problems of judgment to symptoms of a clinical disorder.

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GENDER & SEXUAL SCIENCE: WHAT WE HAVE LEARNED IN THE 50 YEARS SINCE THE KINSEY REPORT

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SEX ADDICTION: A DANGEROUS CLINICAL CONCEPT

Marty Klein, Ph.D

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There is a question that we, as professionals, have all been devoting thousands and thousands of hours to: How can we conceptualize and evaluate (and diagnose and treat, if necessary) sexual behavior? And how do we do this in a *sex-positive* way?

Moreover, how can we maintain a model of sexual health that is sex-positive? The media and the government are not our allies in this. Neither are professions like medicine and psychology.

I believe the concept of sex addiction provides an excellent example of a model that is both sex-negative and politically disastrous. By examining it through a sexological lens, we can understand why it is so problematic and highlight the urgency of developing a new model.

THE SEX ADDICTION MOVEMENT

The sex addiction movement focuses on important issues that deserve sexological attention. Since the mid-80's it has looked at such issues as: questions of lust and desire; the relationship of love and sex; decision-making and impulse control; guilt and shame; and, recently, brain chemistry. These are important sexological questions, and they deserve our attention.

But the sex addiction model is based on a group of assumptions that many sexologists do not share. The main ones are:

- sex and sexual desire are dangerous
- there is only one “best” way to express sexuality
- sex that enhances “intimacy” is the best sex
- imagination has no healthy role in sexuality
- people need to be told what kinds of sex are wrong/bad
- if you feel out of control, you are out of control
- laws and social norms define sexual health

These assumptions create serious limitations in how the sex addiction movement has answered key sexological questions. Most of these answers are pathology oriented. And they pathologize sexual behavior and impulses that are *not* unhealthy. They are also clinically incomplete: they don't address issues of diagnostic clarity, they don't alert us to the differences between character disorders, personality disorders, obsessive-compulsive disorder, post-traumatic stress disorder, and so on.

The sex addiction movement's answers are also culturally bound. As we progress through a new century, we're increasingly aware of cultural issues in sexual behavior—the differences between the way that people think and behave if they were born into rural or urban lives, the differences among age and ethnic groups, differences in family size, education, religiosity, and so on. The same sexual behavior simply means different things when different people do it.

And finally, a lot of the answers generated by the sex addiction movement have been exploited politically. We have seen how some of these ideas have been used to harm the people that we treat, and even to harm the field of sexology. This may not be the intention of the sex addiction movement, but we should be honest about how the movement's ideas have been used by the government, the media, right-wing activists, and by other people to harm our profession.

CRUCIAL LIMITATIONS OF SEX ADDICTION MODEL

- pathology oriented
- pathologize non-problematic behavior
- clinically incomplete
- without context (both individual and situational)
- culturally bound
- politically exploited

A CLINICAL MODEL

All clinical professionals, including not just sex therapists but marriage counselors, social workers, nurse practitioners, and so on, have certain requirements for their clinical models. Those requirements include: consideration of *subjective context*, including how people experience themselves; *clinical sophistication*, including the means by which one diagnoses is made over another; *an emphasis on personal agency*, including the ability to create change for ourselves; and *cross-cultural insight*, including an awareness of which cultural categories are salient for differences in sexual expression.

Working clinicians want our models to value professional expertise, and as such they should minimize self-diagnosis. It is loathsome that the media or other institutions take psychopaths like Ted Bundy as clinically insightful when

they describe their destructive behavior as caused by addiction to sex or pornography. But that's where this model inevitably leads.

And so political and public policy utility are important. Whether you're a therapist working in a private office, an agency, or any other sexological setting, a valuable model of sexuality and sexual health must also be of value in the public policy arena.

WHAT PROFESSIONALS REQUIRE IN A CLINICAL MODEL

- considers subjective context
- clinical sophistication, including differential diagnosis
- based in personal agency and responsibility
- cross-cultural insight
- minimizes self-diagnosis

SOCIAL CONTEXT

As social scientists, we understand that models of sexual normality, and therefore of sexual symptomatology, are constructed—they are part of a cultural discourse. What, then, is the social context in which sexual normality and sexual symptoms are being constructed today?

Here are some of the features of America's cultural landscape which our patients, our colleagues, our legislators, and our media know as the discourse of sexuality in America today:

- self-help movement
- *Oprah* and other “therapeutic” talk shows
- emphasis on victimhood
- cultural anxiety about sexual violence
- increasing medicalization of sexuality
- increasing public awareness of non-normative sexual behavior
- increasing legitimacy of religious concepts and solutions
- increasing political clout of sex-negativity
- cultural acceptance and mythologizing of 12-step programs

These form the discourse, the cultural context, for anyone who is practicing clinical work or developing models of sexuality today.

THEORETICAL BASIS

The theoretical material that shaped America's public consciousness about sexuality from after World War II until about 1980 came from sexologists such as Kinsey, Masters and Johnson, Shere Hite, Lonnie Barbach, and Bernie Zilbergeld. The material that these sexologists generated

shaped the consciousness of several generations of patients, as well as professionals trained from the fifties into the eighties.

The theoretical material that has shaped the public discourse about sexuality in the last couple of decades, however, has *not* come from sexology, but from a completely different source. In this regard, three of the most important books of the last 25 years are *Women Who Love Too Much*; *Men Are From Mars, Women Are From Venus*; and *The Courage To Heal*. They have shaped the way both lay people and professionals think about sexuality.

Other cultural institutions and forces that have been shaping the way people think about sexuality for the last 25 years include the repressed memory movement, the sexual-trauma self-help movement, the Dworkin/McKinnon anti-pornography movement, the pharmaceutical industry, and right-wing political activism.

This is the historical and cultural context from which the sex addiction movement emerged. It is a logical extension of this discourse. Rather than being based on a sexological paradigm, it is a narrative about fear, danger, powerlessness, and victimization—things like trauma and repressed memory. In fact, it is an instructive example of a sexual viewpoint that people develop when their primary goals are to address fear and anger.

IMPLICATIONS OF THE MODEL

The diagnostic criteria for sexual addiction are easy to find on the internet (www.sexhelp.com/sast.cfm). The *Sexual Addiction Screening Test* was developed in the mid-1980s and is still used today. It has 25 questions. Here is one-third of the test:

- Do you regularly purchase porn or romance novels?
- Are you preoccupied with sexual or romantic thoughts?
- Do you feel your behavior isn't normal?
- Does your partner complain about your behavior?
- Are you worried your behavior will be discovered?
- Do you have multiple romantic involvements?
- Do you use sex or romantic fantasies for escape?
- Do you regularly participate in S&M?

These are the kinds of questions clinicians are told they can ask patients, or non-patients, to determine whether or not they are “sex addicts.” Would you want to use criteria like these to determine if your patients, your mate, your best friend, or yourself are pathological (“sex addicted”) around sexuality?

Such diagnostic criteria have inevitable implications. For example, the sex addiction model inevitably believes that eroticism needs to be controlled, and that erotica and commercial sex are dangerous and problematic. It follows then, that the sex addiction movement would have to believe that public policy should be focused on controlling

sexuality. In this regard it has been very successful.

The sex addiction movement must also inevitably say that people are in danger of becoming addicted and thereby lose their ability to make wholesome choices. We're told that at some point something can happen to healthy people—they can, for example, consume a lot of pornography—and they can become addicted. And so everyone's at risk. The sexual addiction diagnostic criteria make problems of non-problematic experiences, and as a result pathologize a majority of people. This is a serious deficiency in the model.

Recently, some people have started to speak of "cybersex addiction." We read extraordinary figures that suggest 6 to 10% of the population is "addicted to cybersex." This is a predictable outgrowth of the sex addiction concept. When newer technologies are developed and adapted for sexual use in the near future (virtual sex, perhaps?), we can expect to hear about how many people are "addicted" to that as well.

The sex addiction movement exploits people's fear of their own sexuality. This fear is one of the major public health problems facing America today. Men and women are so frightened of their own sexuality that they project this danger onto other people, and become frightened of other people's sexuality. Americans are frightened about

their neighbors who go to nude beaches, or to swing clubs. People have learned to be afraid of their neighbor's sexuality because they've been encouraged to be afraid of their own sexuality.

Given the ways in which our culture is sex-negative, the diagnostic criteria for sex addiction are in harmony with people's fundamental sexual assumptions and experiences. If you grow up in America, you are, of course, concerned about your neighbors finding out about your sexuality. You, of course, have parents who are frightened or ashamed of their sexuality. If you use pornography, you will, of course, want to hide it from your mate. The kinds of things that the sexual addiction model says reflect problematic behavior are simply common sense—if you grow up in a sex-negative culture.

BEHAVIORS AND DIAGNOSES

The chart below lists behaviors that clinicians see in everyday practice. From the sex addiction perspective these behaviors are easily seen as symptoms of sex addiction. However, look at the *possible* diagnoses that a different kind of clinical sexologist could make. I emphasize possible, because each one of these is only one possible diagnosis; true diagnosis depends on the person.

BEHAVIOR	DIAGNOSIS ACCORDING TO SEXUAL ADDICTION MODEL	POSSIBLE DIAGNOSIS ACCORDING TO CLINICAL SEXOLOGY
masturbates twice daily	sex addict	not necessarily a problem
extramarital affairs	sex addict	existential dilemma
wants partner sex daily	sex addict	not necessarily a problem; personality disorder
enjoys sadomasochism	sex addict	not necessarily a problem
uses inappropriate come-ons	sex addict	socially inept; narcissism
exhibitionism	sex addict	obsessive compulsive disorder
wants non-monogamy	sex addict	borderline; adventurous
married but cruises bathrooms	sex addict	tormented about sexual orientation
fetish behavior	sex addict	self-aware
commercial sex	sex addict	committed to marriage; social anxiety
uses Internet porn	sex addict	depression; dissatisfied with sexual partner

Take someone, for example, who has extramarital affairs. Perhaps what this reflects is an existential dilemma—she’s 50 years-old in a routine marriage, wondering “is this how I’m going to spend the rest of my life?” Or someone who does not want to be monogamous—maybe they have a borderline personality disorder, or maybe they’re adventurous. A good clinician would have to talk to the person before making a diagnosis; we would have to find out a lot more about a person before we could say we know the meaning of that person’s interest in non-monogamy.

Or take a person who is interested in commercial sex. Maybe he is committed to his passionless marriage, and rather than leave it, or have an affair and risk falling in love with somebody, he goes to a prostitute once a week. I’m not willing to say that this man is a “sex addict,” even though he feels terribly guilty about seeing a prostitute regularly, can’t really afford it, and wishes he weren’t doing it. Warm and understanding people could perhaps persuade him that he’s a “sex addict,” but without several interviews, we cannot possibly say that this person is truly out of control.

Yes, there is such a thing as sexual compulsivity and obsessive-compulsive disorder. Skillful therapists are using cognitive-behavioral techniques and medication with such patients. Long-term therapy is a helpful addition with some. Most people who self-diagnose as “sex addicts” aren’t compulsive, however. They’re mostly unremarkable people who simply don’t like the consequences of their sexual choices—but do not want to deal with the emotional distress that would arise if they made different choices. Conventional therapy (generally less than six months) works well with many of these men and women.

A HISTORICAL PERSPECTIVE

If we look at the last 150 years, we see many conditions that the finest scientific minds of their age classified as illnesses which we now understand are not pathological. For example, if you go back to the 1860s, ‘70s and ‘80s, the finest scientists said that libertinism—being “too” interested in sex—was a disorder. At the turn of this century, the finest medical minds said that masturbating was a serious disease. Carol Groneman’s *A Brief History of Nymphomania* shows how that diagnosis has been used for the last 100 years as a form of social control.

In addition, people who advocated birth control in the 1920s were labeled psychiatrically ill. And we all know that frigidity and homosexuality have been labeled psychiatric diseases. Sex addiction fits right into this tradition of “diagnosing” non-conforming sexual expression as disease.

SOME SEXOLOGICAL “DISEASES” OF THE PAST

- libertine
- masturbator
- nymphomaniac
- birth control advocate
- frigid
- homosexual

MOVING FORWARD

In contrast to that tradition, America desperately needs a model of sexual *health*, a model that is clinically complex and culturally informed. We need a model of sexual health that does not pathologize a broad range of eroticism. We need a model that is supportive of adult identity. Being an adult is complicated and scary, and sometimes it is very difficult. A lot of people would like to make their sexuality so simple that being a grownup becomes less scary. The clinical sexologist’s job is to help people understand that while it is, in fact, scary to be a grownup, there are tools that can help them deal with their fear. We don’t have to strip down their sexuality to take away the darkness, the complexity, the ambiguity, just so people can be more comfortable.

Finally, America needs a model of sexual health that is *sex-positive*. And that’s the challenge that the sex addiction movement is posing to sexology. They’ve come up with their model, sex-negative and politically disastrous as it is. Can we come up with something different that’s culturally sensitive and contains other sex-positive features? Something that policy-makers can use without destroying kids’ sex education or adults’ sexual rights? That’s the challenge that we as a profession face. How are we going to respond to that challenge?

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COMPULSIVE SEXUAL BEHAVIOR: WHAT TO CALL IT, HOW TO TREAT IT?

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Like most behaviors, sex can be taken to extremes. It can become excessive, impulsive, obsessive, compulsive, driven, and distressing. Some people suffer with these behavioral problems to the point that it interferes with their daily lives.

Unfortunately, clinical sexologists appear unable to reach consensus on what to call or how to treat such sexual behavior. Terms used to describe this phenomenon include *hypersexuality*, *erotomania*, *nymphomania*, *satyriasis*, and, most recently, *sexual addiction* and *compulsive sexual behavior*. The terminology often implies different values, attitudes, and theoretical orientations, and we remain in a quagmire about classification, causes, and treatment.

DEBATE OVER CAUSE

Disagreement exists as to whether compulsive sexual behavior is an addiction, a psychosexual developmental disorder, an impulse control disorder, a mood disorder, or an obsessive compulsive disorder.

Patrick Carnes popularized the concept of compulsive sexual behavior as an addiction. He believes that people become addicted to sex in the same way they become addicted to alcohol or drugs. Although this theory has become popular in recent years, it remains quite controversial and many other theories exist.

Robert Barth and Bill Kinder have argued that compulsive sexual behavior is an impulse control disorder.¹ Others have argued that it is a variation of an obsessive compulsive disorder.² A relatively new hypothesis put forth by John Bancroft and Erick Janssen explains sexual disorders as dysregulations of our excitatory and inhibitory mechanisms.³

The more psycho-dynamically oriented theorists have described this syndrome as a psychosexual disorder.⁴ Heinz Kohut views it as a disorder of the self and an intimacy disorder.⁵ Sexologist John Money conceptualizes it as lovemap pathology—a developmental and psychosexual disorder resulting from deprivation in, or punishment for, normal sexual rehearsals in infancy and childhood and/or from childhood trauma or abuse that would impair love and love bonding.⁶ Money implicates cultural factors as well for potentially creating schisms between “love” and “lust” that result in the development of psychosexual disorders.⁷

While I have seen compulsive sexual behavior as an example of an “intimacy dysfunction” stemming from childhood abuse and trauma and highly restrictive attitudes about sexuality, I now view the behavior as having a multitude of causes and presentations.⁸

In my work and throughout this article, I use the term *compulsive sexual behavior (CSB)* to describe this syndrome. I chose this term in an attempt to find language that would describe the clinical phenomenon but leave open the possibility for multiple treatments. However, I recognize the limitations of this term, because the word *compulsive* is retained even though not all the behaviors of the syndrome are driven by obsessive-compulsive mechanisms.

While I continue to use the term *compulsive sexual behavior*, I hope it is understood that this is still a description of a set of symptoms waiting for a better term to replace it.

CLASSIFICATION OF COMPULSIVE SEXUAL BEHAVIOR

Compulsive sexual behaviors can be divided into two main types: paraphilic and nonparaphilic.

Paraphilic compulsive sexual behavior. Paraphilic behaviors are unconventional sexual behaviors that are obsessive and compulsive. They interfere with love relationships and intimacy.

In early editions of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, these unconventional behaviors were referred to as sexual deviation.⁹ However, influenced by Money’s work, the term *paraphilia* was introduced into the classification of sexual disorders in the *DSM-III*.¹⁰ This term was viewed as more precise and non-pejorative. As a consequence, the classification is generally accepted within clinical sexology, but not without criticism.¹¹

In the recent *DSM-IV*, paraphilias (or unconventional sexual behaviors) are defined as “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one’s partner, or (3) children or other non-consenting persons.” The definition goes on to explain, “The behavior, sexual urges, or fantasies cause clinically

significant distress in social, occupational, or other important areas of functioning.”¹²

Although Money has defined nearly 50 paraphilias, there are currently eight paraphilic disorders recognized in the *DSM-IV*: *pedophilia*, *exhibitionism*, *voyeurism*, *sexual masochism*, *sexual sadism*, *fetishism*, *transvestic fetishism*, and *frotteurism*.¹³

Some behaviors, such as sado-masochism, when they are consensual and do not impair life functioning, are not considered a paraphilia because they do not meet all of the diagnostic criteria.

Nonparaphilic compulsive sexual behavior. Nonparaphilic compulsive sexual behavior involves conventional behaviors which, when taken to an extreme, are recurrent, distressing, and interfere in daily functioning.

The *DSM-IV* describes one example under the heading of “Sexual Disorders Not Otherwise Specified” as “distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used.”¹⁴ Other examples include: compulsive fixation on an unattainable partner, compulsive masturbation, compulsive love relationships, and compulsive sexuality in a relationship.¹⁵

Not all sexual behaviors that cause problems necessarily reach a diagnostic threshold. Nor are there well-established clinical criteria to define such behavior.¹⁶ In the past, we have used a slight alteration of the paraphilia diagnostic criteria. In my own thinking, I propose the following criteria to define nonparaphilic compulsive sexual behavior:

- a. involves recurrent and intense normophilic (nonparaphilic) sexually arousing fantasies, sexual urges, and behaviors that cause clinically significant distress in social, occupational, or other important areas of functioning; and
- b. is not due simply to another medical condition, substance use disorder, or a developmental disorder

It is important not to label “problems” prematurely and ignore intra-/inter-sociocultural considerations that might better explain the behavior. In developing diagnostic criteria, we must take the norms of gender, sexual orientation, and sociocultural groups into consideration.

BEHAVIORS IN CONTEXT

In fact, there are those who do not believe in sexual addiction or even in the idea of compulsive sexual behavior as a disorder. Their main criticism of these concepts is the possibility of overpathologizing behavior. They fear that the pathologizing of sexual behaviors (either by professionals or individuals) may be driven by anti-sexual attitudes and a failure to recognize the wide range of normal human sexual expression.

Individuals might think they are suffering from compulsive sexual behavior when, in reality they are experiencing behaviors that are part of sexual development, that are sexual problems but not compulsive, or that are simply in conflict with their values.

In order to avoid overpathologizing, it is important for professionals to be comfortable with a wide range of normal sexual behavior—both types of behavior and frequency of behavior. And it is important to look at all sexual behaviors in context.

Sexual development. Individuals might view some sexual behaviors as obsessive or compulsive when they do not view them within a developmental context. Adolescents, for example, can become “obsessed” with sex for long periods of time. Adults commonly go through periods when sexual behavior may take on obsessive and compulsive characteristics. Individuals might naturally become obsessed with their partner and feel compelled to seek out their company and to express affection in early stages of romance. These are healthy processes of sexual development and must be distinguished from compulsive sexual behavior.

Sexual problems. It is common for people to have sexual problems that are not pathological. People can make mistakes. They can at times act impulsively. Their behavior can cause problems in a relationship. Some people will use sex as a coping mechanism, just as they may use alcohol, drugs, or eating. These patterns of sexual behavior are sometimes problematic. They are often remedied by learning from mistakes or learning healthier forms of sexual expression. By its nature, the clinical syndrome of compulsive sexual behavior is much more resistant to change.

Conflict with values. Many patients identify that they have compulsive sexual behavior when it is more a matter of conflict over intrapersonal values. For example, they might view masturbation, oral sex, homosexual behavior, sado-masochistic behavior, or a love affair as compulsive because they disapprove of these behaviors.

It is, therefore, very important to distinguish between individuals who have a values conflict with their sexual behavior and those who engage in compulsive sexual behaviors. Similarly, individuals may have a conflict with their values and those of their partner, family, or culture. Sometimes the problem is a matter of interpersonal or intercultural conflict.

TREATMENT

While we are still in search of a consensus of terminology, cause, and diagnostic criteria, it is important to recognize

that there are a number of types, patterns, and manifestations of compulsive sexual behavior. It is prudent to look at this as a syndrome that calls for a variety of treatment approaches.

12-step groups. For those who view compulsive sexual behavior as an addiction, 12-step groups modeled on Alcoholics Anonymous (AA) are a logical place to turn for treatment. There are a plethora of self-help groups such as Sexual Addicts Anonymous (SAA), Sex and Love Anonymous (SLA), and Sexaholics Anonymous (SA). Each is modeled after AA and each uses the 12 steps and traditions of AA as a basic philosophy and guide.

There are reports that this approach is successful.¹⁷ In fact, there are many people who seek help only through such groups. Certain practitioners base their treatment on this methodology, or use these groups as an adjunct to their treatment.¹⁸

This method, however, remains controversial. Many feel that the “abstinence model” useful for alcoholics cannot be applied to sexuality since sexual expression is a basic need of life. Critics view the abstinence solution as an oversimplification of compulsive sexual behavior and potentially dangerous when proper medical and psychological treatment is not provided.

While I have argued about the dangers of the “addiction model” and 12-step groups,¹⁹ my clinical experience has shown that some patients find these groups extremely helpful as an adjunct to treatment and that others find them neutral or problematic. In addition, many patients find the term “addiction” a useful metaphor to describe their problem.

Although I still have concerns about the “addiction model” and 12-step groups, I do not see 12-step groups under professional guidance as necessarily incompatible or harmful. Obviously, we are in need of more rigorous study of the effectiveness of these groups.

Psychotherapy. There are a number of psychotherapeutic treatment models. Again, given diagnostic considerations, it is important that we consider such treatment on an individual basis.

My colleagues and I have found that group therapy, augmented with individual and family therapy, has been very effective as a cornerstone of treatment.²² However, we also individualize treatment plans within the group. And, certainly, not all patients should be treated in group, given diagnostic considerations.

My colleagues and I have also found a high rate of personality disorders in our patients—certainly a variety of personality disorder traits that are intertwined in their management or mismanagement of interpersonal relationships.

Psychotherapy can prove very helpful in uncovering the sources of these management strategies and helping patients to learn more adaptive management mechanisms.

Treatment should also go beyond the removal or reduction of symptoms and help individuals learn new skills in psychosexual functioning. Beyond control of the affective states (especially anxiety and depression), in many cases more emphasis needs to be placed on addressing basic identity and intimacy functioning. Many of our patients with long-standing patterns of dysfunctional sexual behavior know very little about healthy sexuality and intimacy. Thus, a large part of treatment and after care should focus on developing a positive and healthy sexuality.

Pharmacology. There are a number of pharmacologic treatments that have proved effective in clinical case studies.²⁰ Antidepressants that selectively act on serotonin levels in the brain are effective in reducing sexual obsessions and compulsions and their associated levels of anxiety and depression. The newer medications interrupt the obsessive thinking and help patients control urges to engage in CSB. They also help patients use therapy more effectively. Medications that suppress the production of male hormones (antiandrogens) can also be used to treat a variety of paraphilic disorders.

John Bradford has developed an algorithm of pharmacologic treatment of paraphilic compulsive sexual behavior based upon his clinical experience in treating sexual offenders and support from the clinical literature.²¹ It relies heavily on the use of SSRIs (Selective Serotonin Reuptake Inhibitors) in mild cases and on antiandrogen treatment in extreme cases.

We are in need of a similar algorithm for nonparaphilic compulsive sexual behavior. While the antiandrogens could be used in more severe cases, there are a variety of other medications and combinations of medications which could be used to control less severe cases. Although the behavior may be distressing, it does not involve sexual offending behavior. Therefore, I have significant concern about the use of antiandrogens to control nonparaphilic CSB because of side effects and the fact that it also suppresses normophilic functioning, which we are interested in enhancing. We need to look at the effectiveness of other regimens with less potential problems of side effects and those that will not interfere in normophilic functioning.

Fortunately, there is now an array of pharmacologic treatments proven effective in clinical case studies. However, we are still in desperate need of controlled clinical trials in order to develop a more evidenced-based clinical approach to pharmacologic treatment.

CONCLUSION

A challenge remains to understand nonparaphilic compulsive sexual behavior, find where this clinical syndrome fits in our classification of sexual disorders, determine clear diagnostic criteria, and find effective treatment approaches.

While the debate over the past few decades has been helpful, we are in desperate need of more research. Meanwhile, we must learn to recognize this clinical syndrome in individuals and know when to apply the appropriate methodology based upon our best available scientific understanding of the complexity of possible causes and treatments.

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AN APPROACH TO PHARMACOTHERAPY OF COMPULSIVE SEXUAL BEHAVIOR

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Compulsive sexual behavior, while not an official diagnosis in the psychiatric and psychological fields, is a well-recognized clinical problem. A better understanding of the etiology of compulsive sexual behavior would be helpful in understanding the disorder and directing treatment. In the meantime, clinicians must rely on case reports, a few open-label trials, clinical experience, and clinical judgment to make recommendations to their patients with this disorder.

Certainly clinicians in the area report marked improvement with adequate pharmacotherapy for compulsive sexual behavior. Adequate treatment and improvement of symptoms can lead to improvement in psychosocial functioning and decreased risk of contracting sexually transmitted diseases.

COMORBID DISORDERS

Psychiatrists treating patients with compulsive sexual behavior must remember that as a group, these individuals usually have a high prevalence of other mood, anxiety, and substance use disorders.¹ It is difficult, if not impossible, to treat the sexual disorder without also addressing these related disorders.

The literature indicates that mood disorders, primarily depression, are common in patients with compulsive sexual behavior.^{2,3,4} Studies indicate that approximately 70 percent of these patients are diagnosed with mood disorders at some point in their lives. Estimates of anxiety disorders range from about 50 to 90 percent.

Substance use disorders also affect at least half of the individuals, particularly alcohol and marijuana abuse or dependence. These are often best addressed by treatment programs specifically designed to support sobriety.

Sobriety is an important prerequisite to psychotherapy or medications directed at treating compulsive sexual behavior or the comorbid psychiatric disorders. Active substance abuse decreases the efficacy of attempts at treatment.

USE OF SRIs

Antidepressants that increase the brain neurotransmitter serotonin are often the first choice for psychiatrists treating individuals with compulsive sexual behavior.

Neurotransmitters are the naturally occurring substances produced by brain cells to communicate with other brain cells. Serotonin has consistently been found to be low in

individuals with depression. Low serotonin levels are associated with impulsive and aggressive behaviors in individuals.⁵

When patients with impulse control problems are treated with serotonin reuptake inhibitors (SRIs), they often report decreased frequency and intensity of urges to engage in the impulsive behavior. They also report increased ability to exercise conscious control over a response to an urge.

Individuals with compulsive sexual behavior have reported similar benefits from SRIs.⁶ In addition, they also report that relief from the moods and anxiety symptoms that often accompany their sexual problem enables them to exercise more control over their sexual urges and behaviors.

Many patients also suffer from preoccupation with thoughts of sexual activities or sexually arousing fantasies. SRIs have also been found to be useful in decreasing obsessive thinking in a number of different psychiatric disorders.

Therefore, the SRI antidepressants can be used to accomplish several goals: (1) improve depressed mood; (2) decrease anxiety; (3) decrease urges; (4) increase control over urges to engage in compulsive sexual behavior; and (5) decrease obsession and ruminative thinking patterns.

SIDE EFFECTS OF SRIs

SRIs are well known to have sexual side effects, particularly decreased libido and delayed orgasm. It has been suggested that these side effects may be responsible for the efficacy of these medications in the treatment of compulsive sexual behavior. However, we have found the opposite to be true.

Instead of reducing the preoccupation with their sexual behavior, we have found that the medications that have sexual side effects often make this worse. For example, if patients with compulsive sexual behavior experience delayed ejaculation, they report that they spend even more time engaging in sexual behavior or sexual fantasy in order to experience climax. For this reason, we most often prescribe an SRI that is less likely to cause sexual side effects such as: escitalopram (Lexapro™), sertraline (Zoloft™), or citalopram (Celexa™).

Adding medication such as nafazodone or bupropion to an SRI can reduce the sexual side effects of the SRI. These medications may be used in addition to or instead of an SRI to avoid the sexual side effects. However, used alone

these medications may not have the same efficacy as an SRI in reducing impulsive or obsessive behavior.

NEW TREATMENTS

Recently, our research group at the University of Minnesota has published two case reports on the use of an opiate antagonist, naltrexone (Revia™) in reducing urges to engage in compulsive sexual behavior.^{7,8}

The theory regarding the use of this medication in impulse control disorders was based on work by S.W. Kim, who suggested that the neuro-anatomical pathway that subserves urges to engage in impulsive behaviors may be the same pathway that subserves drug cravings and the rewarding property of substances of abuse.⁹ Activity in this pathway is reduced by use of the opiate antagonist naltrexone (Revia™).

Our research group has seen marked reductions in urges to masturbate compulsively, to engage in anonymous sex, and to engage in computer pornography in patients with severe compulsive sexual behavior. Caution should be used with the use of naltrexone, as higher dosages that are often needed to treat compulsive sexual behaviors can be harmful to the liver.¹⁰ Liver damage is much more likely to occur if naltrexone is taken with pain medications such as ibuprofen (Motrin™), acetaminophen (Tylenol™), or aspirin. Liver function tests must be performed regularly to ensure no damage is occurring.

Looking at comorbid conditions can also help us identify other potential treatments. For example, in his comorbidity studies, Martin Kafka has found a high prevalence of adult attention deficit disorder in his patients with compulsive sexual behavior.¹¹ He advocates treatment of the attention deficit disorder to help control impulsive sexual behavior. While stimulants such as methylphenadate (Ritalin™) and dextroamphetamine still remain the most common treatments for attention deficit disorder, new medications such as the recently released atomoxetine (Stratera™) may be effective while avoiding the potentially addictive properties of the stimulants.

Other potential medications include the antidepressant bupropion (Wellbutrin™) and the medication modafanil (Provigil™) that is approved for treatment of narcolepsy. Mood stabilizers such as valproic acid (Depakote™) and lithium can be particularly useful in patients with mood instability or comorbid manic-depressive spectrum disorders. Both of these medications have also been used with success in various disorders where patients exhibit problems with impulse control. For the patient that exhibits comorbid thought disorders or psychotic disorders, one of the newer atypical antipsychotics such as risperidone (Risperdal™), olanzapine (Zyprexa™), or quetiapine (Seroquel™) can be added to the regimen.

CONCLUSION

Ultimately, much more research is needed in the way of controlled treatment trials to determine the efficacy of any

of these medications in the treatment of compulsive sexual behavior. In order to conduct rigorous treatment trials, we need to come to a consensus on specific diagnostic criteria for compulsive sexual behavior and on a uniform method to operationalize its definition.

It should be noted that many clinicians in this field, while finding medications useful in the treatment of compulsive sexual behavior, think that concurrent psychotherapy is often needed for the individual to develop healthy sexual behavior and attitudes. At the same time, patients in concurrent psychotherapy often report that they are able to make more rapid progress in therapy once their compulsive sexual behavior and comorbid disorders are adequately treated.

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GLOBAL AIDS BILL WILL EXPORT ABSTINENCE - ONLY - UNTIL - MARRIAGE PROGRAMS

William Smith

SIECUS Director of Public Policy

SIECUS has argued for several years that the abstinence-only-until-marriage movement was building a basis of domestic support that would eventually provide a springboard for exporting this unproven and potentially dangerous approach overseas.

GLOBAL AIDS BILL

On May 27, President Bush confirmed our analysis and sealed the deal by signing the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, more popularly known as the Global AIDS Bill. With its passage, the movement has gone global, and the President can claim another victory for the far right.

In fact, the White House's involvement in the shaping of the bill was critical and intense at every stage—including the insertion of harmful abstinence-only-until-marriage language that prevents one-third of the bill's prevention funds from focusing on the use of contraception, including condoms.

Following the momentous announcement of a \$15 billion U.S. commitment to the global HIV/AIDS effort in Bush's State of the Union address in late January, a bipartisan bill emerged in the International Relations Committee of the U.S. House of Representatives.

THE HOUSE ACTS

The importance of this original bill cannot be overstated because at the helm of the compromise, as reported in this column, were the most ideologically divergent members of the House.

The architects of the bipartisan bill were U.S. Reps. Henry Hyde (R-IL), Tom Lantos (D-CA), Barbara Lee (D-CA), and Dave Weldon (R-FL).

Rep. Hyde has been *the* undisputed stalwart of the anti-choice movement in the House during his nearly three-decade-long stint representing Illinois' Sixth District. Rep. Weldon, now in his fifth term, has emerged as new blood for the anti-choice movement and has become the lead crusader against condoms and a comprehensive approach to sexual health. Conversely, Rep. Lee is a lead sponsor of the federal Family Life Education Act (FLEA), a

bill that would provide the first federal investment in a comprehensive approach to sexuality education, and has been a champion of progressive HIV prevention efforts. Rep. Lantos has also always been a strong supporter of reproductive rights and sexuality issues.

Rumors of discontent began to surface just prior to the International Relations Committee's full consideration of the bill—then known as HR 1298. A great deal of pressure had been generated by extreme conservative Republican members of the House and the Pro-Life Caucus, concerned that the bill did not adequately enumerate a primary emphasis upon abstinence. Never on the sidelines of these issues, right wing extremist groups added their own voices to the mix. Focus on the Family, for example, characterized the bipartisan bill as an "airlift for condoms."

Responding to the pressure, the White House waited until the very eve of lawmakers' consideration of the bill on March 20 to indicate its opposition. According to the Washington, DC, newspaper *The Hill*, Rep. Hyde's office had been operating under the assumption that the White House was "generally supportive" of the bill. They arrived at this conclusion after they were briefed by Administration officials who did not indicate opposition to the bill.

By the time the House passed the bill on May 1, a number of disturbing elements had found their way in. Chief among these was the abstinence-only-until-marriage provision. Set along side it was an exemption for faith-based groups who receive funds under the bill to exclude information about contraception and condoms if it is inconsistent with its religious teachings.

Both provisions were supported by the Bush Administration, though it indicated its willingness to sign the bill without them. A third provision was also added calling for a prevalence study of human papillomavirus (HPV). Domestically, supporters of the abstinence-only-until-marriage approach have used HPV as a scare tactic that dissuades the use of condoms, claiming they provide no protection against the virus.

Finally, language was included that would require all grantees under the bill to have an explicit written policy opposing prostitution and sex trafficking.

THE SENATE ACTS — KIND OF

On May 16, the Senate took up consideration of the House version of the bill. The decision was not without debate. Behind the scenes, several Senate bills were floated and considered. But again, the White House intervened by creating an air of urgency.

The White House let it be known that the President had an impending visit in June to Evian, France, to meet with the G8, a group of the leading industrial countries. Should the President have the bill in hand, the argument went, he could use it as a symbol of U.S. leadership on HIV/AIDS and urge other G8 nations to demonstrate similar commitments.

The White House's strategy not only assured that the House version would be taken up but also made clear that any Senate changes would thwart the Administration's timetable for finalizing the legislation. Thus, in addition to taking the House bill and all its flaws, Senate Majority Leader Bill Frist (R-TN) was instructed by the White House to reject any amendments that had not been previously cleared by House Majority Leader Tom DeLay (R-TX). Such a strategy would assure identical pieces of legislation that would not need to be reconciled and could therefore swiftly land on the President's desk for his signature.

The tactical maneuvers of the White House enabled the defeat of every Democrat-offered amendment to the bill except one amendment providing debt relief for those nations most severely stricken by AIDS {offered by Senator Joseph Biden (D-DE)}.

On the issue of the abstinence-only-until-marriage provision, the vote could not have been more guided by ideology and politics. Senator Dianne Feinstein (D-CA) offered an amendment to strike this language but it failed

45-52. Two Democrats voted against the measure—moderates Ben Nelson (D-NE) and Zel Miller (D-GA). However, not a single Republican strayed from the White House's dictum and voted for the measure. This is particularly disturbing since both of Maine's Republican Senators, Olympia Snowe and Susan Collins, had previously indicated a commitment to a comprehensive approach to prevention efforts.

WHAT NEXT?

The irony of the Global AIDS bill is that it is simply an authorizing bill. It lacks the commitment of a single dime. The actual allocation of money will fall upon the House and Senate appropriators to negotiate during deliberations over Fiscal Year 2004 spending bills.

To be sure, there is good news in this bill. The most liberal of estimates suggest the support provided by the law could prevent seven million new infections, care for 10 million HIV-positive people and orphans, and provide needed treatment medicine for two million.

Still, the law sets forth language that indicates the United States embraces prevention efforts that wholly exclude information about contraception and/or dissuade condom use.

Twenty-three years ago, language like this slipped into our domestic prevention efforts. Today, abstinence-only-until-marriage programs are a multi-million dollar industry replete with trinkets of every sort.

Real leadership would have allowed those countries most affected by HIV/AIDS to use our generous commitment in ways that were most needed and reflected community norms. Instead, an Administration gearing up for reelection has tossed yet another bone to the right wing.



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Submitting Articles and Book and Audiovisual Reviews for Publication in the *SIECUS Report*

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To expedite production, submissions should adhere to the following guidelines:

PREPARATION OF MANUSCRIPTS

Feature articles are usually 2,000–4,000 words. Book and audiovisual reviews are typically 200–600 words.

Manuscripts should be submitted on 8½ x 11 inch paper, double-spaced, with paragraphs indented. Authors should also send a computer disk containing their submission.

All disks should be clearly labeled with the title of submission, author's name, type of computer or word processor used, and type of software used.

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The beginning of an article should include the title, subtitle, author's name and professional degrees, and author's title and professional affiliation.

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