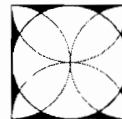


Recognition and Management of Addictive Sexual Disorders: Guide for the Primary Care Clinician

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With greater awareness of sexual exploitation, professional sexual misconduct, and the sexual issues of public figures, a growing awareness of the problem of sexual addiction is emerging. As a result of public awareness, more cases will be brought to the attention of primary care providers. When primary care providers are confronted by problematic sexual behavior that fits the parameters of addictive illness, they should know what the implications are in order to make appropriate clinical decisions and to evaluate treatment approaches. The purpose of this article is to summarize the nature of the problem, to review critical issues in assessment, to provide treatment options, and to suggest critical factors for monitoring progress.

(Key words: addiction, treatment options for sexual disorders)

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 with destructive results. The essential problem that all clinicians have is first to identify that they are facing an issue of sexual compulsivity.

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. This includes being deceptive with their physician because of their immense shame about their behavior. If they hold any type

of leadership position (church, business, community, or political), the fact that they are to be models of moral behavior compounds the problem in that their position adds to their shame and fear.

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, an unwanted pregnancy, an emergency room visit, and a car accident while being sexual all are among the many occasions for such a visit. The most likely scenario is that the problematic event will be presented as a unique situation or simply as a moral lapse.

Oftentimes, the primary care provider will treat the resulting physical problem without probing for further information. If, however, there is sexual addiction, the problem will not disappear without further intervention. A wide range of behaviors can be problematic including compulsive



masturbation, affairs, pornography use, prostitution, voyeurism, exhibitionism, sexual harassment, and sex offending. Seldom do these patients engage in just one behavior, but rather in a collection of behaviors. For example, in addition to multiple affairs, there might also be problems of prostitution, pornography, cybersex, and compulsive masturbation. Health care providers must be aware that underneath what appears to be an isolated event may be a more complex pathologic problem with a host of comorbid factors such as the following:

- A high incidence of depression and suicidality
- The presence of high-risk and dangerous behaviors including self-harm designed to escalate sexual experiences
- The high probability of coincidence of other addictive behaviors including alcoholism, drug abuse, and pathologic gambling
- Sex addiction is a key factor in recidivism in other addictive illnesses
- Extreme disruption of the family coincident with family issues including battering, sexual abuse, and financial distress as well as with family members experiencing physical harm, depression, and other addictions themselves
- A significant factor in the spread of the human immunodeficiency virus (HIV) epidemic
- The common occurrence of aversion desire disorder (sexual anorexia) in partners
- The loss of job, reduction of productivity, and in some cases loss of career

If primary care providers ask questions, they may find an untold story of great pain and relief that someone knows what the problem is. The following case examples illustrate the primary care provider's role in intervention:

Case A. A physician was consulted by a patient and his wife about the acceptability of cross-dressing. In private interviews, the clinician discovered that the cross-dressing

involved significant prostitution and high-risk anonymous sex. The financial losses were staggering between the cost of prostitutes and lost work time, all of which the wife had no direct knowledge. In a private interview with the spouse, when the physician asked about the wife's problem with obesity, she admitted to being a sexual abuse victim, to having anxiety attacks about fear of her husband leaving her, and to compulsive overeating to cope with it all. Because the cross-dressing patient was a physician and there was concern about behavior with employees, the patient was referred to an inpatient facility.

Case B. A male patient had a sexually transmitted disease (STD) diagnosed by his nurse practitioner, who suggested that his wife also be examined. The patient started to sob and indicated that this had happened before, and that his wife had said if it happened again, there would be an end of the marriage. Additional history revealed that the patient had a consistent pattern of infidelity and prostitution use, and that he liked "teens." He was an airline pilot, which provided considerable opportunity, and a devout Mormon, which created considerable dissonance. The nurse practitioner was able to get the patient to a 12-step meeting and a therapist who had groups for sex addicts and their spouses. The nurse practitioner treated the STD and monitored the case, talking to both the patient and the therapist.

Case C. A woman reported to her physician that she had vaginal irritation. The physician asked what the patient thought was the cause. The patient broke down and reported that she was a sexual abuse victim, that sex worked only if a man was hurting her or pain somehow was involved. She used various chemicals that were irritating to her vagina because it was the only way she could achieve orgasm masturbating. A complete assessment revealed that the patient was pursuing sado-masochistic activity compulsively with her husband and with others. Moreover, she was escalating dramatically the risks she was taking. When the physician talked with



the wife and the husband, the husband became defensive and said, "But you taught me how to do this!" The patient responded by saying, "Yes I created my own nightmare." The physician also determined that there was alcoholism in the patient and probably the husband as well. The physician treated the vaginal problem and referred the couple to an inpatient multiple addictions program.

Understanding Problematic Sexual Behaviors as Addictive Disorders

This section describes a working definition of addiction, how it can be applied to out-of-control sexual behaviors, and a differential diagnosis of such behaviors. To facilitate classification and understanding of psychological disorders, mental health professionals rely on the *Diagnostic and Statistical Manual of Mental Disorders*, now in its fourth edition (DSM-IV, 1994). Each edition of this book represents a consensus at the time of publication about what constitutes mental disorders, and each subsequent edition has reflected a changing understanding. The DSM system is therefore best viewed as a "work in progress" rather than the "bible."

The term "sex addiction" does not appear in the DSM-IV. In fact, the word "addiction" itself does not appear anywhere in this book. However, the criteria listed for various addictive disorders, such as substance dependence and pathologic gambling, can be condensed into the same three key elements: (1) *Loss of control (compulsivity)*: "There is a persistent desire or unsuccessful efforts to cut down or control substance use." "Has persistent unsuccessful efforts to control, cut back, or stop gambling." (2) *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 fi-

nance gambling." (3) *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." (DSM-IV, pp. 181, 618). When a set of sexual behaviors fulfill the same three criteria, the person can be considered to have a sexual addiction. Note that tolerance and withdrawal are not mentioned in this discussion: Many drugs of abuse are not associated with tolerance and do not have specific withdrawal symptoms, so these features are not essential for the diagnosis of addiction.

The value of the addiction model is that it leads to a specific treatment approach, which is described in the following discussion. For many affected patients, the use of more traditional treatments such as psychoanalysis or insight-oriented therapy (in the belief that once the behavior is understood, it will stop) or even punishment such as incarceration has failed. It is well accepted that psychotherapy for alcohol dependence is likely to fail until the drinking has been directly addressed and stopped. The addiction model posits that the same is true for many persons whose sexual behavior is compulsive.

Any sexual activity can be compulsive, including those considered normal and healthy such as masturbation and consensual sexual intercourse. However, some sexual behaviors are considered abnormal. These are listed in the DSM-IV under the heading of paraphilia. The chief feature of a *paraphilia* is that what is desired sexually is objectified: What matters is the particular body part (e.g., a foot) or item of clothing (e.g., an undergarment) or age (e.g., a child), or sequence of activities.

Another major advantage of the addiction approach is that such patients tend toward many types of sexual activities, both normal and abnormal. They will use several behaviors simultaneously or in a specific hierarchy of preference. Clinical diagnoses based on specific behaviors such as the paraphilia miss the dynamic and interactive quality of patient choices.



Differential Diagnosis

Other diagnoses must be considered in the differential diagnosis of excessive sexual activity, including the following:

- Impulse control disorders
- Bipolar affective disorder
- Posttraumatic stress disorder
- Adjustment disorder (a temporary change of behavior)
- Substance-induced disorders
- Dissociative disorders
- Delusional disorders (erotomania)
- Obsessive-compulsive disorder
- Gender identity disorder
- Delirium, dementia, or other cognitive disorder
- Personality disorders

Schneider and Irons (1996) described how these disorders can be expressed as excessive sexual behavior. An addiction specialist is in the best position to rule out these diagnoses. Some of them, however, may be quite apparent to the primary care practitioner. For example, a hypersexual patient who is in the manic phase of bipolar illness usually demonstrates other features of the disorder such as grandiose thinking, rapid speech, excessive activity, and short attention span. A person whose sexual behavior has been disinhibited by a high concentration of alcohol in the brain is likely to exhibit other signs of intoxication. A patient whose sexual behavior has been disinhibited by Alzheimer's disease will show other cognitive deficits. As for adjustment disorder, this is a temporary situation related to current stresses or events in a person's life. For example, a person who is in the midst of a divorce may demonstrate significant but temporary behavior changes. In contrast, an addiction is a pervasive pattern of behavior that is present for months and years.

Finally, characterologic disorders can be the primary cause of excessive sexual behaviors. For example, persons with antisocial or narcissistic personality disorder may have sexual contact with multiple partners, but the reason is that the other person is

viewed simply as an object to be used for one's own sexual pleasure, not because there is loss of control.

Sexual Behavior Patterns

The following are situations that should prompt a health care provider to gather more sexual history:

- The patient volunteers that there is a long-term pattern of sexual acting out behavior. There are occasions when addicts simply give in to despair, letting their primary care provider know the trouble into which they have gotten themselves.
- There are physical complications to sexually excessive or illicit behavior. Many sex addicts tell the story of a caring primary care provider who asked how "this" happened and thus opened the door to recovery. A nonjudgmental and informed primary care provider can help by letting the addict tell his or her provider how bad it is and helping them with the resources they need.
- The primary care provider has evidence that there is a pattern of behavior. For example, if the primary care provider knows that there is a pattern of affairs and broken relationships and then learns that the patient is using massage parlors or prostitutes, a pattern starts to emerge. A thorough sexual history showing a pattern of sexual acting out or high-risk behavior over time also would indicate a problem.
- There is a sexual incident, and the physician knows that other excessive behaviors such as alcoholism, compulsive eating, compulsive working, or compulsive gambling also exist (or a history of those behaviors exist) in addition to evidence of a sexual problem. Most often addictive and compulsive behaviors occur together and amplify each other, or these behaviors can replace each other. For example, a recovering alcoholic may maintain alcohol sobriety but start bingeing sexually.



- There are signs of depression, and the patient reports using sex to cope with sleeplessness or despair. Most addictions have a very high comorbidity with acute depression. For many sex addicts, the depression is about their sexual behavior and their inability to stop.
- The behavior involves the abuse of power including sex with children, congregants, employees, patients, or other persons under the authority of the patient. Any exploitation of power or report of exploitation should immediately trigger an assessment for addictive disorders.
- There are unexplained problems coupled with a sexual incident. Unexplained absences, failure to perform expected tasks, and the disappearance of large sums of money all could be part of a compulsive pattern. Many times family members will communicate problems to the physician, who will start to make sense of what is happening that the family cannot.

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 clinically it would not be a compulsive pattern. Nor does exploitive or even violent behavior mean addictive illness. In a recent study of sex offenders, only 72% of pedophiles and 38% of rapists fit the criteria of addictive illness (Blanchard, 1990).

It should be noted that women as well as men can have the problem. In fact, for every three men there is one woman with sexual addiction. The ratio absolutely parallels gender ratios in compulsive gambling and alcoholism. The expectation of many that women would not have the problem, and certainly not moral or religious women, helps to keep the problem secret. These patients double the shame. First there is the shame of having a sexual problem with loss of control, and then there is the shame of being a woman who has lost control.

Sexual addiction therefore can be very diverse. Since 1985, the authors have been gathering data on sex addicts (Carnes, 1991). Using an inventory that asks about 170 different sexual behaviors, a series of factor analyses show that sexually addictive behavior clusters into 10 distinct types of behavior. Patients tend to do many of the behaviors listed in each cluster. Table 1 summarizes these 10 types. Furthermore, the authors learned that patients often will be active in more than one cluster of behaviors. That is one of the important lessons of sex addiction. Patterns do not exist with just specific behaviors but among behaviors. Therefore, the exhibitionist will rely on prostitution as a less risky way to act out, and in so doing is not different from someone who uses prostitutes, compulsively cultivating a series of affairs. The astute health care provider will see the bridge across these behaviors as the sexual loss of control and ask if there are life-damaging consequences as a result. The larger patterns will emerge from this inquiry.

Cybersex: The Crack Cocaine of Sex Addiction

A new problem involves actually helping to clarify the understanding of sex addiction for many professionals. People are using cybersex in unexpected numbers, and many are finding themselves accessing sex in problematic ways. Sex addicts have found sex on the Internet to be a natural extension of what they already are doing. Any of the 10 types of behavior can be done on the Internet. The sex addict can find sex partners, be voyeuristic, start affairs, locate prostitutes, and swap partners. In short, anything that can be done sexually can be done on the Web. However, researchers such as Cooper (1999) in his analysis of data collected through cable news network MSNBC point to the fact that there also are individuals who never would have experienced sexually compulsive behavior had it not been for the Internet. These factors, in addition to the sheer volume of patient reports, have prompted the phrase that "cybersex



TABLE 1
Sexual Behavior Patterns

Fantasy sex: Sexually charged fantasies, relationships, and situations
Arousal depends on sexual possibility. Neglecting responsibilities to engage in fantasy and/or prepare for the next sexual episode is common among fantasy sex addicts.

Seductive role sex: Seduction of partners
Arousal is based on conquest and diminishes rapidly after initial contact. Arousal can be heightened by increasing risk and/or number of partners.

Voyeuristic sex: Visual arousal
The use of visual stimulation to escape into an obsessive trance. Arousal may be heightened by masturbation, or risk (e.g., peeping) or violation of boundaries (e.g., voyeuristic rape), but in order for arousal to be maintained it must be illicit somehow and be visual.

Exhibitionistic sex: Attracting attention to body or sexual parts of the body
Sexual arousal stems from reaction of viewer shock or interest.

Paying for sex: Purchase of sexual services
Arousal is connected to payment for sex and, with time, the arousal actually becomes connected to money itself. Payment creates an entitlement and a sense of power over meeting needs, but the arousal starts with "having money" and the search for someone in the "business."

Trading sex: Selling or bartering sex for power
Arousal is based on gaining control of others by using sex as leverage.

Intrusive sex: Boundary violation without discovery
Sexual arousal occurs by violating boundaries with no repercussions.

Anonymous sex: High-risk sex with unknown persons
Arousal involves no seduction or cost and is immediate. The arousal has no entanglements or obligations associated with it, and often is accelerated by unsafe or high-risk environments such as bars, beaches, parks, and rest rooms.

Pain exchange sex: Being humiliated or hurt as part of sexual arousal, or sadistic hurting or degrading another sexually, or both
Arousal is built around specific scenarios or narratives of humiliation and shame.

Exploitive sex: Exploitation of the vulnerable
Arousal patterns are based on target "types" of vulnerability. Certain types of vulnerable persons (e.g., clients/patients of professionals; children or adolescents; distressed persons) become the focus of arousal.

has become the crack cocaine of sex addiction." Here are recent facts to consider:

- There are 200 new web sites for pornography each day and more than 100,000 existing sites.
- Sexually explicit activities on the Web, not counting chat rooms and dating services, constitute the third largest economic sector on the Internet, with only sales of software and computers being larger.
- A total of 65 million unique visitors use not-for-pay porn sites, and 19 million unique visitors use pay porn sites each month.
- Most pornography is downloaded from 9 a.m. to 5 p.m. during the workday.



- Of every 100 employees, 6 use company time to download pornography. Some average as much as 25 hours a week in this endeavor.
- Approximately 1% of Internet users have a very severe cybersex problem that focuses almost exclusively on cybersex, with major neglect of the rest of their life's activities. Many of these cybersex addicts are women.

The problem has become so severe that the major medical journal dedicated to sex addiction issues, *Sexual Addiction and Compulsion, the Journal of Treatment and Prevention*, has dedicated a special issue to clinical problems resulting from cybersex (Cooper, 1999).

Sexual Disorders in Patients Who Are Addicted

Sexual dysfunction is a frequent concomitant of addiction, whether the addiction is to drugs, sex, or both. The causes of the dysfunction are both physical and psychological. Physical effects of some addictions can decrease sexual desire, performance, or both. In the case of alcohol, short-term use is disinhibiting, so it may improve performance. But long-term use in men decreases the male sex hormone and increases female hormone levels, which can decrease both sexual interest and performance.

In opioid addicts, sedation decreases sexual interest. Stimulant (cocaine, amphetamine) addicts typically demonstrate increased (often compulsive) sexuality in the early stages of the addiction, but eventually lose both interest and ability as the addiction progresses. A common report of patients who are cocaine addicts is that the ability to ejaculate diminishes. However, addicts will masturbate without ejaculation for many hours to the point of physical exhaustion or physical harm to genitals.

Psychologically, addicts generally come from dysfunctional families that did not provide them with role modeling of healthy relationships and healthy sexuality. Sex ad-

dicts in particular often were victims of sexual abuse in childhood (Carnes, 1991), or at least experienced extreme attitudes about sex. Sex may have been overvalued (sexual jokes and innuendoes, excessive interest in sex, pornography in the home), or it may have been a preoccupation, but in a negative way. There were rigid rules to prevent people from being sexual and sometimes even from thinking sexual thoughts. Religion may have been used by the parents to justify the sex-negative attitudes. Alternatively, sex simply may not have been discussed and no information given.

Studies show that about 80% of women alcoholics were sexually abused in childhood. Sexual abuse in childhood distorts sexuality (Maltz & Holman, 1993). In early adulthood, survivors seem either to become socially and sexually withdrawn from their peers or to plunge into a phase of promiscuous and sometimes self-destructive sexual activity. In other words, they gravitate to one or the other extreme of sexual behavior, to either sexual anorexia (aversion desire disorder, DSM 302.797), or sexual compulsivity. In some people, these are just phases, but for others they become permanent features of their lives. On the other hand, a sexually compulsive phase will be replaced by sexual aversion. Carnes (1997) argued that the interchange of aversion and compulsion in that sense can parallel what happens in eating disorders.

Individuals who have any addiction give first priority to their addiction; the couple relationship is less important. This engenders anger and resentment in the partner, which further damages the relationship. Spouses (or partners) of addicts typically come from family backgrounds similar to those of the addicts. They also lack role models for healthy relationships, healthy sexuality, and intimacy. Both partners need education and counseling.

When it is recalled that many people are addicted to both sex and drugs, it becomes apparent why the primary care practitioner needs to obtain a sexual history for drug addicts and a drug history for sex addicts.



Clues for the Practitioner

Physical Consequences of Sexual Addiction

The preceding discussion outlines various consequences of out-of-control sexual behavior. Loss of one's job, legal consequences, divorce or marital discord, financial problems, fears of being discovered in secret activities, the shame and guilt often felt by addicts all can bring on depression, anxiety disorders, and posttraumatic stress disorders. However, the sex addict will most likely be brought to the attention of the primary care practitioner by the physical consequences of the addiction. Table 2 lists some of these potential consequences, which are discussed in the following sections.

Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) such as HIV disease, herpes, syphilis, gonorrhea, and chlamydia are contracted through direct genital contact. This can be prevented largely through the use of condoms. Unfortunately, compulsive sex is often unsafe sex. Sex addicts in the midst of their rituals (regular methods of preparing for sexual activity to take place) are in an altered state of mind, focused on gratifying their urges. In this state, they are "on automatic pilot" and often do not even think

about safe versus unsafe sex. Only after the sexual contact is completed does remorse, guilt, and fear of infection set in.

In a survey of more than 1000 male and female sex addicts, Carnes (1991) found that 38% of the men and 45% of the women contracted STDs as part of their addictive behavior. Furthermore, 64% of the addicts had continued their sexual behavior despite the risk of disease or infection.

The risk of acquiring an STD is significantly increased by the concomitant use of alcohol and other drugs, even when drugs are not injected. Among heterosexuals entering alcohol treatment in San Francisco, unsafe sexual practices were common: 54% had multiple sexual partners in the previous year, and 97% of nonmonogamous patients did not use condoms during any sexual encounters (Avins et al., 1994).

There also is a strong connection between methamphetamine abuse and high-risk sexual behavior. In the 6 months before entering treatment, 70% of methamphetamine users reported having sex while under the influence of the drug, and 30.5% never used a condom despite having more than one sexual partner (Gulati, Gonzales, Huber, & Ling, 1999). In a review of 16 epidemiologic studies relating crack cocaine use, sexual behavior, and STDs, 15 of the studies reported a connection, often related to an exchange of drugs for sex and lack of self-care when an individual is on the drug (Marx et al., 1991). Another likely reason for the connection is the frequent coexistence of multiple addictions in one person. This phenomenon is well known to the primary care practitioner, who is aware that alcoholics are more likely than nonalcoholics to be heavy smokers, and heavy smokers are more likely than nonsmokers to be heavy drinkers. The same is true of other addictions. Several studies have shown a correlation between sex addiction and chemical dependency (Carnes, 1991; Rawson and Washton, 1998; Washton, 1989).

Certain implications for the primary care practitioner are clear. A patient who presents with recurrent STDs may be sexu-



TABLE 2

Physical Consequences of Sex Addiction

- Sexually transmitted diseases
- Unwanted pregnancies and complications of abortion
- Rape and/or physical abuse/victimization
- Physical injuries to genitals, breasts, colon, etc.
- Self-abuse (e.g., cutting, burning, bruising)
- Motor vehicle accidents
- Unintentional injuries
- Suicide attempts, completed
- Alcohol-related accidents
- Alcohol-related injuries



ally addicted, requiring evaluation. Similarly, the patient who repeatedly requests an HIV test may be engaging in unsafe sex with multiple partners and may have lost control over his or her sexual behavior. Alcohol and other drug abuse should also be considered in such patients.

Unwanted Pregnancies and Complications of Abortion

In Carnes' (1991) survey of sex addicts, almost 70% of the women routinely risked unwanted pregnancy by not using birth control. As a result, 40% of the women did in fact have unwanted pregnancies, and 36% of them had abortions. Children conceived in obsession and the resulting high abortion rate exacted a high level of shame, rage, and guilt among the sexually addicted women. The primary care practitioner should obtain a thorough sexual history from women who have had unwanted pregnancies.

Victims of Rape or Physical Abuse

Half of the female sex addicts in Carnes' (1991) survey had experienced rape, as had 7% of the men. The corresponding figures for physical abuse by another person were 60% of the women and 16% of the men. These high figures often were related to the tendency of sex addicts to engage in high-risk sexual behaviors, to frequent unsafe places, and to hang out with unknown or dangerous people. Often, the connection with such people is made in a bar, and the addition of alcohol and other drugs to the equation inflates the risk of violence (Irons & Schneider, 1997). In fact, 79% of women and 44% of men in Carnes' survey reported having found themselves in potentially abusive or dangerous situations.

In the same survey, 42% of sex addicts also were chemically dependent. Several studies have found an association between female drinking and increased victimization by husbands (Kaufman-Kantor & Straus, 1989; Miller, Downs, & Testa, 1993). It is likely that women addicted to both sex and alcohol are at a particularly high risk of being raped, physically abused, or both.

Physical Injuries From Sexual Activity

Physical injury as a part of compulsive sexual activity is surprisingly common. Such injury was reported by 30% of the men and 38% of the women in Carnes' (1991) survey. Some sexual activities caused physical harm because of their violence, use of objects, or inherent danger. Some injuries resulted from sadomasochistic sexual activities, others from excessive masturbation. Gannon (1990), a urologist, reported treating multiple penile lesions including extensive penile bruising as a consequence of frequent manipulation, self-inflicted burns to the penis, and removal of penile skin.

Each year urologists, surgeons, gynecologists, and emergency room physicians examine patients who have inserted foreign objects into their urethras, bladders, rectums, and external genitalia. Many patients repeatedly insert objects into themselves. Many present with self-inflicted trauma to their genitals.

Gannon (1990) presented several case histories, including that of a woman who, starting at the age of 15 years, achieved erotic sensation by alternately inserting thermometers into her urethra, tampons into her vagina, and cigar cases into her rectum. She had grown up in a home where her manic-depressive mother spent much time compulsively cleaning her young daughter's genitals, giving her enemas, and spanking her. Her father had multiple affairs and was frequently absent.

A study of patients who self-insert concluded that "as a group, their childhoods were globally dysfunctional with chaotic home lives, aggressive and antisocial behavior, school and sexual disorders, and a prior history of self-abuse" (Kenny, 1988). The majority of sex addicts have experienced physical, sexual, and/or emotional abuse in childhood (Carnes, 1991). Health care practitioners who see patients with problematic sexual behavior, including genital injury, usually treat the presenting problem without exploring the underlying psychological disorder, which in some cases includes sexual addiction. Genital injuries



should alert the practitioner to the possibility that sex addiction is present.

Self-Abuse Not Directly Related to Sexual Activities

Cutting, burning, bruising, and other self-injurious behaviors were reported by 9% of the men and 36% of the women in Carnes's (1991) sample of sex addicts. Self-harm is a common adult sequela of childhood trauma (Herman, 1992). Most sex addicts were victims of some type of abuse in childhood. Many addicts use self-mutilation as a way of control themselves sexually and expressing sexual self-hatred (Carnes, 1991).

Motor Vehicle Accidents

As illustrated in the films "Parenthood" and "The World According to Garp," sexual activities in a moving car can result in a motor vehicle accident. Carnes (1991) reported that 19% of male and 21% of female sex addicts had experienced a car accident as a result of driving while masturbating, exposing one's body, or participating in some other sexual behavior. Such behavior also can include being preoccupied with sexual thoughts, diverting one's attention to men or women on the street or in other cars, and searching for prostitutes, pornographic stores, and opportunities for voyeurism instead of attending to the driving. The practitioner who sees a patient after a motor vehicle accident needs to request information about the specific circumstances of the accident, especially if the patient appears to have been at fault.

Unnecessary Surgeries

In our youth-oriented society, many emotionally healthy men and women undergo face-lifts, hair transplants, laser resurfacing, liposuction, breast implants, and other cosmetic procedures in a quest to improve their appearance. Some individuals, however, have these procedures performed under duress at the request of a spouse or partner on whom they are overly dependent, or on their own initiative in an

attempt to increase their sexual appeal to a spouse who appears to have lost interest. Still others undergo cosmetic procedures to enhance their sexual appeal and improve their chances of success in the sexual marketplace. Some in this latter group are sexually addicted.

Abuse of Agents Reputed to Be Sexual Performance Enhancers

Amyl nitrite, a vasodilator, has been used for many years by men as part of their sexual activity with other men. Termed "poppers," because the agent came in glass ampoules, this medication was inhaled after the vial was broken. Amyl nitrite is no longer prescribed in the United States, but a related, less potent chemical, butyl nitrite, is often available over the counter in pornographic establishments. Amyl nitrite does not enhance erections. Its action is to relax smooth muscle throughout the body, including the anal sphincter, so it is used to facilitate anal intercourse. It also causes a sudden rush of oxygen into the brain, which is perceived as a euphoric, disinhibiting experience.

Any drug used to improve sexual performance in men with erectile dysfunction can be misused. At a recent workshop, several cases of men who abused Viagra were presented (Irons, Schneider, & Sealy, 1999). One example was a man dually addicted to cocaine and sex. He would spend hours involved in a ritual of sexual activity and cocaine inhalation. Both activities were a necessary part of his ritual. In the past, his cocaine-sex binges came to a natural end when his postorgasmic refractory period prevented further sexual arousal. However, when Viagra became available, he dosed himself repeatedly during binges to allow the rapid return of erections. In conjunction with the abuse of Viagra, his cocaine-sex binges were lengthened significantly and his risk of adverse consequences increased.

A married elderly man frequently visited prostitutes. Without Viagra, he was able to function sexually only two or three times a week. However, with the use of this



drug, he developed a pattern of one or two daily visits to prostitutes. The availability of Viagra led to intensification of his compulsive sexual behavior.

Another drug deserving of mention is flunitrazepam (Rohypnol), a short-acting benzodiazepine whose notoriety comes from its use as a facilitator of date rape. Ten times more potent than diazepam (Valium), this drug, neither manufactured nor approved for medical use in the United States, is smuggled in from Mexico and other countries. Rohypnol is taken most often with alcohol, and because it is odorless and tasteless, it sometimes is slipped into the drinks of unsuspecting victims. Rohypnol produces profound sedation and reduces the will to resist sexual advances (Schwartz & Weaver, 1998). It also causes anterograde amnesia (i.e., inability to remember what occurs during the 6 to 8 hours during which the drug exerts its action). In a study of 904 young women who used Rohypnol voluntarily, 10% reported experiencing physical or sexual victimization while under the drug's influence (Rickert, Wiemann, & Berenson, 1999).

Other Clues for the Primary Care Practitioner

Presence of Other Addictions

Sexual addiction often coexists with chemical dependency and frequently is an unrecognized cause of relapse. This is particularly true with cocaine addiction. Wash-ton (1989) reported that 70% of cocaine addicts entering his outpatient treatment program were found to be addicted to sex as well. Many patients had become trapped in a "reciprocal relapse" pattern, in which compulsive sexual behavior precipitated relapse to cocaine or vice versa.

In a more recent survey of the sexual behaviors demonstrated by cocaine and methamphetamine addicts in treatment, 76% of male methamphetamine and 51% of male cocaine addicts reported obsession with sex, whereas 64% of male methamphetamine addicts and 42% of male co-

caine addicts reported that their sexual activity while under the influence of their drug of choice felt "perverted" or "abnormal" (Rawson, 1988). The tendency of sexual activity to promote relapse to drug use was confirmed by the finding that sexual fantasies triggered drug use in 40% of male methamphetamine addicts and 47% of male cocaine addicts. Although chronic cocaine use eventually impairs sexual function, tolerance does not develop for the intensified libido and sexual fantasies stimulated by cocaine (Rawson & Washton, 1998). The long-term cocaine addict whose sexual dysfunction leaves him no way to satisfy his sexual fantasies may intensify his sexual obsessions even more.

Activation of eating disorders also can be related to sexual addiction. Carnes (1997) described a 41-year-old woman who had four marriages. When married, she would eat compulsively, put on about 60 pounds, and develop sexual aversion. Between marriages, she would lose the weight, become anorexic in her food intake, and switch to being sexually addictive. At any one time, her weight was inversely proportional to her level of sexual compulsivity. Such cases are not isolated. Huebner (1993) described sexual acting out as a frequent concomitant of binge eating and anorexia. Many studies of trauma victims show cycles of binge and purge activity with food and sex, including the studies of Renshaw (1997) and Schwartz (1996a). Frequently, clinicians observe compulsive athleticism as an extension of eating disorder and connected with sexually compulsive behavior (Yates, 1991).

Binge-purge cycles are used by some sex addicts in an attempt to regulate weight. The primary care practitioner who suspects the presence of sex addiction is advised to inquire about the patient's eating habits.

Information Obtained From Other Family Members

One of the most reliable and helpful clues to the presence of any addiction is in-

formation obtained from concerned family members. Most primary care practitioners have received a version of the following phone call: "My husband has an appointment with you today. He won't say anything about this, but I'm worried about his drinking..." When both family members are your patients, a diagnosis in one patient can sometimes provide useful information on the other. In one of the authors' medical practice, the following situations have occurred:

1. Over the course of a year, a woman repeatedly requested testing for HIV and other STDs. She stated she was monogamous, but admitted that she believed her husband was visiting prostitutes frequently.
2. A woman presented with anxiety and depression. She explained that her husband, whose business takes him out of town, had experienced multiple affairs, but she could not imagine leaving him.
3. A woman reported fatigue and insomnia. Despite long hours at the family business, she could not sleep. Discussion revealed that her husband often was up all night on the computer engaged in cybersex and masturbation, then was exhausted during the day, and that their joint business was on the verge of bankruptcy.

In each case the author was unaware that her male patient was engaging in sexually compulsive behaviors that had potential medical consequences. Although primary care practitioners cannot discuss information about a patient with a family member without the patient's permission, nothing prevents them from listening to a family member's concerns and making use of the information thus acquired.

Intervention and Treatment

Primary care providers are in a unique position to assist sex addicts in beginning recovery. Patients sometimes trust their primary care provider, with whom they will share

that they are having problem. If the primary care provider asks about the behavior, is warm and supportive, and knows about the problem, the probability is even higher the patient will confide. Also, the primary care provider often is the one who witnesses the moment at which many addicts experience such great consequences to their behavior that they know they must do something. Like all addicts, sexually addicted persons operate with significant delusion and denial. When reality forces its way into the addict's life, an understanding primary care provider can say it is time to do something.

The first action step is to help the addict to understanding the problem. Table 3 lists key books to read and key organizations to contact. The list also includes books and organizations for family members. As the patient develops awareness, it is very useful to conduct a thorough sexual history to determine the extent of the problem. Oftentimes, the patterns extend back to the patient's very earliest memories of childhood. The patient may very well self-diagnose at this point, or the primary care provider may need to assist in seeing how the patient's life fits the criteria for sex addiction. If the primary care provider is uncomfortable with making a final diagnosis, referral can be made to an addiction specialist who knows about sex addiction.

From the outset, the primary care provider should encourage a complete physical. Many times, sex addicts have physical problems that they have ignored or are too ashamed to talk about, most commonly undiagnosed STDs. However, there also are injuries or unusual sex practices that have caused either problems or anxiety. The physician must insist on examining the genitals and the anus. When patients resist that examination, it usually means something too shameful to show anyone is wrong. In the authors' experience, every time they have met resistance, it has stemmed from a big secret about a physical problem.

The physician must be aware that certain physical problems appear in the early recovery of sex addicts including acute depres-



TABLE 3

National Addresses of 12-Step Programs for Sex Addiction

For the addict

The following programs differ primarily in their definition of "sexual sobriety." In cities when more than one of these programs have meetings, many addicts attend them interchangeably.

Sexaholics Anonymous (SA)

P.O. Box 111910
Nashville, TN 37222-1910
(615) 331-6230
e-mail: saico@sa.org

Sex & Love Addicts Anonymous (SLAA)

P.O. Box 650010
West Newton, MA 02165-0010
(617) 332-1845
e-mail: slaafws@aol.com

Sex Addicts Anonymous (SAA)

P.O. Box 70949
Houston, TX 77270
(713) 869-4902
e-mail: info@saa-recovery.org
web: <http://www.sexaa.org/>

Sexual Compulsives Anonymous (SCA)

Old Chelsea Station, P.O. Box 1585
New York, NY 10013-0935
(800) 977-HEAL
web: <http://www.sca-recovery.org/index.html>

For the partner or family member:

The following two programs, both for families and friends of sex addicts, have no significant differences in their philosophy. Generally, only one or the other is well represented in any one city.

S-Anon International Family Groups

P.O. Box 111242
Nashville, TN 37222-1242
(615) 833-3152
e-mail: saifg@sanon.org

Codependents of Sex Addicts (COSA)

P.O. Box 14537
Minneapolis, MN 55414
Phone: (612) 537-6904
e-mail: cosa@shore.net
web site: <http://www2.shore.net/~cosa/>

For couples

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

For information on education, conferences and referrals

National Council of Sexual Addiction and Compulsivity (NCSA/C)
1090 Northchase Parkway
Suite 200 South
Marietta GA 30067
770-989-9754

For peer reviewed medical literature about sex addiction/compulsivity

Sexual Addiction and Compulsion: The Journal of Treatment and Prevention
800-821-8312 ext. 117

For more resources on sex addiction

www.addictionresearch.com

For complete database and bibliography of information on sexual addiction

www.addictionresearch.com

Recommended Reading List

Carnes, P. J. (1991). *Don't Call It Love*. New York: Bantam Books.

Carnes, P. J. (1996). *Addiction or compulsion:*

Politics or illness? Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention 3, 2.

Earle, R., Earle, M., & Osborn, K. (1995). *Sexual Addiction Case Studies and Management*. Brunner/Mazel.

Goodman, A. (1998). *Sexual Addiction: An Integrated Approach*. International Universities Press

Schneider, J. P. (1988). *Back From Betrayal*. New York: Ballantine Books.

sion, sleeplessness, irritability, and difficulty concentrating. Nausea often occurs for those who experience deep despair over their behavior. These symptoms parallel what happens for cocaine addicts, persisting for 21 days and tailing off over the next 2 months.

For addicts who have other addictions as well, this is an extremely trying period.

Success Factors

A number of key factors accompany successful recovery:



1. *A good addiction-oriented primary therapist:* Most successful recoveries involve a relationship with a therapist over a 3- to 5-year period, the first 2 years of which are very intense.
2. *A 12-step sex addiction group:* The probability of relapse is extremely high if the addict does not attend meetings.
3. *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 attend the same fellowships your patient does. That way, there is a consolidation of relationships.
4. *Program work, not just attendance:* Completing step work, finding a sponsor, and doing service all are key elements of recovery. Health care provider support of these activities must be beyond attendance. In a recent outcome study of an inpatient program for sex addiction, researchers discovered that only 23% actually complete the first 9 of the 12 steps in 18 months. Of those who did, recidivism was rare.
5. *Early family involvement:* Just involvement of family members in the patient's therapy ups the success rate.
6. *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.
7. *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.

Table 4 is a summary of responses that 190 recovering sex addicts made to various forms of intervention indicating what was and what was not helpful. It should be noticed that spirituality and 12-step involvement were key.

Inpatient Versus Outpatient Treatment

Health care providers on occasion will be confronted with the choice of inpatient or outpatient treatment. Obvious criteria exist for inpatient treatment including suicidality or failure of an outpatient approach. Sometimes the sex addict will be in such a crisis because of consequences—legal, financial, marital, or public exposure—that the case will be very difficult to manage in an outpa-

TABLE 4
Followup Survey of What Was Helpful in Recovery (N = 293)

Type of Treatment	Helpful (%)	Not Helpful (%)
Inpatient treatment	35	2
Outpatient group	27	7
After care (hospital)	9	5
Individual therapy	65	12
Family therapy	11	3
Couples therapy	21	11
12-step group (SA based)	85	4
12-step group (Other)	55	8
Sponsor	61	6
Partner support	36	6
Higher power	87	3
Friend's support	69	4
Celibacy period	64	10
Exercise/nutrition	58	4



tient setting. When there are multiple addictions such as those involving cocaine and sex, stopping addictive behavior can be extremely difficult in an outpatient program. The withdrawal issues alone are overwhelming. One of the best indicators of success is patient willingness. If there is family support and the patient is committed, outpatient programs may be the best match. If there is significant distress in the family, and if patient has multiple addictions and significant delusion about the extent of the problem, inpatient care may be the approach of choice.

Health care providers also may encounter situations in which sex addiction is a problem for another health care provider or professional such as an attorney or clergyman. In some such cases, there may be abuse of power in sexual exploitation of staff, patients, or clients. It is always important in those situations to insist on an independent evaluation to determine the course of treatment. Irons and Schneider (1999) have argued effectively that these situations are too complex for treatment to be initiated without an extensive multidisciplinary assessment.

Healthy Sexuality

Finally, it should be remembered that the goal of treatment is healthy sexuality. Recovery does mean abstinence from self-destructive sexual practices. Some therapists do insist on a period of celibacy, which does help to reduce chaos, make the patient more available for therapy, and provide a window of time to work on sexual abuse issues. The objective is to develop a healthy, strong sexual life. One of the risks is that the patient may slip to a position of sexual aversion in which all sex is bad. Sexual aversion or "sexual anorexia" is simply another variant of sexually compulsive behavior. Patients will bounce from one extreme to the other. Recovery involves a clear understanding of the sex from which to abstain and a clear, active plan for enhancing sexuality.

Follow-Up Evaluation in Primary Care

Primary care practitioners used to ordering urine drug screens as a means of following up on patients recovering from chemical dependency often ask how a clinician can be sure that a sex addict is indeed on a path of recovery. It should be recalled that traditional follow-up assessment of recovering alcoholics does not include urine drug screens. When such a test is ordered, its purpose is to determine whether the patient is abusing mood-altering substances other than alcohol. Similarly, occasional urine drug screens are indicated for sex addicts, especially if the patient has a concurrent substance use disorder from which he or she is recovering. Urine drug screens should be presented to patients not as a tool for checking up on them, but rather as an opportunity for the patients to demonstrate that they are serious about their recovery and are avoiding illegal drugs. Checking the patient's weight on each visit is an easy means of screening for addiction substitution involving food.

The bottom line, however, is that evaluation of the recovering sex addict, like that of the recovering alcoholic, is best accomplished by means of a dialogue between the patient and practitioner. Table 5 lists some of the elements to be covered. The first two questions are specific to sex addiction recovery, whereas the remainder are applicable to recovery from any addiction. Recovery from chemical dependency requires avoidance of all mood-altering chemicals, so that it is not necessary to keep defining the substances to which the person is addicted.

In contrast, recovery from sex addiction can be likened to recovery from eating disorders. Food is a necessary part of life, and recovery from eating disorders requires defining what is healthful eating and what eating patterns must be avoided. Similarly, the goal of recovery from sex addiction is not to abstain from sex (although sexual abstinence for a brief period is a tool used



TABLE 5

Outpatient Follow-Up of Sex Addicts

- To what are you addicted (i.e., the patient's definition of sobriety)?
- About what are you fantasizing?
- How are you handling HALT (hungry, angry, lonely, tired) in your life?
- What are you doing for your recovery?
- What are you doing for balance in your life?
- What's happening in your primary relationship?

early on), but rather to define what is healthy sexuality for the individual.

Healthy sexuality for most sex addicts involves not only a change in behavior, but also avoidance of fantasizing about behaviors that are unhealthy for them. Sexual fantasizing can be healthy, particularly for a reasonably healthy couple that uses their increased excitement to move toward the partner rather than away. However, sexual imagery that is not respectful of other human beings increases objectification, depersonalization, and destructive bonding based on hostility rather than affection (Schwartz, 1996b). Asking the patient about his or her sobriety definition and about the general content of fantasies provides a clue to sexual addiction recovery in particular.

The remaining questions seek to determine how well the patient is doing in establishing a healthy lifestyle. Does the patient have tools for avoiding relapse during times of hunger, anger, loneliness, and tiredness (HALT)? 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 seeing 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 the spouse or significant other? Is the spouse also attending a self-help meeting? These all are indicators as to whether the patient is engaged fully in building a healthier lifestyle.

A final word to the primary care practitioner is this: You will be much more effective, as well as more comfortable, in following up on a recovering addict if you are familiar with the language and concepts of addiction recovery, especially if you have attended a few 12-step meetings yourself. Some 12-step meetings are "open" to anyone who wishes to attend, whereas others are "closed," meaning that only persons with the addiction can attend. In many cities, sex addiction ("S") recovery meetings are closed to protect the privacy of those who attend. If you are unable to find an open "S" meeting, the same principles and language can be acquired by attending an open meeting of Alcoholics Anonymous. Such meetings are very easy to find, and they welcome visitors. It also is desirable that the practitioner have some knowledge of Al-Anon meetings, the self-help program for families and friends of alcoholics. Because addiction is a family disease, the spouse or partner of the sex addict usually can benefit greatly from attending S-Anon, Co-Sex Addicts Anonymous (COXA), or Al-Anon. Again, the practitioner will be more successful at recommending these meetings if she or he has personal knowledge of what goes on there.

Conclusion

This article reviews the basic situations that a clinician will encounter, which may mean the presence of sex addiction. Specific treatment methods and resources also were specified. The critical factor is the willingness of busy primary care providers to become informed about the sexual lives of their patients. Some primary care providers may be reluctant to talk about sex specifically and in detail. The authors' experience is that an understanding primary care provider can make all the difference for a person to leave



his or her sexual nightmare. Both authors of this article routinely hear of patients who got help and were able to dramatically transform their lives because they talked to their family doctor. We hope this article will make that easier for you to do.

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