The Challenging Landscape of Problematic Sexual Behaviors, Including "Sexual Addiction" and "Hypersexuality"

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There is no concept in the field of sexology that has received as much recent attention or created as much dissension among therapists as sexual behaviors that are perceived as problematic or out of control. For want of a better term, many therapists and the public at large refer to these behaviors as "sexual addiction" (Carnes, 1983). Other labels currently being used for problematic sexual behavior include "sexual impulsivity" (Barth & Kinder, 1987), "hypersexuality" (Kafka, 1997; Stein et al., 1992), "compulsive sexual behavior" (Coleman, 1991; Goodman, 1993; Quadland, 1985), "impulsive/compulsive sexual behavior" (Coleman, 2010), and "dysregulated sexuality" (Winters, Christoff, & Gorzalka, 2010).

All of these labels attempt to anchor problematic sexual behaviors to a specific psychiatric disorder, diagnosis, or treatment paradigm. Yet the growing consensus is that there is no specific disorder that generates the myriad of sexual thoughts, feelings, and behaviors that can cause some people to experience their sexuality—or others'—as being out of control (Coleman, 2003). There can be such a variety of contributing factors that it defies a simple solution or paint-by-numbers approach.

Bancroft and Vukadinovic (2004) prefer the term "sexual behavior that is out of control." Rather than implying etiology or even pathology, this term is descriptive of the problem itself or the way the individual experiences it. Bancroft and colleagues leave it to the individual to determine when his or her sexual behavior is out of control. As a result, one person's normal sexual behavior might be another person's out-of-control behavior. With their choice of terminology, Bancroft and colleagues are focused on learning more about problematic sexual behaviors rather than attempting to create a DSM diagnosis to fit these behaviors. For simplicity's sake, the term *problematic* will be used throughout this chapter to signify sexual feelings, urges, and behaviors that are experienced as being out of control and are causing distress. Specific labels such as "sexual addiction" or "hypersexuality" will be used when appropriate in a given context.

Differences in Perception Among Clinicians and Researchers

The perception of problematic sexual behaviors can vary depending upon the theoretical orientation and personal or religious beliefs of the clinician or researcher (Coleman, 2003). Perceptions can also be affected by the training and specialty of the clinician and the types of patients the clinician sees. For instance, a clinician who works with sex offenders or individuals with paraphilic disorders may think of problematic sexual behaviors differently from a therapist who sees patients with sexual dysfunctions, low desire, or marital problems. A forensic psychiatrist may envision a sex-related diagnosis that would work best in the criminal justice system, while a general practitioner may want a diagnosis for insurance reimbursement, for setting up a treatment plan, or for giving a patient a term that describes his or her condition.

A clinician's theoretical orientation and training can also influence how he or she approaches the personal and social impairments that are often attributed to problematic sexuality such as sexually transmitted infections, lost jobs, unwanted pregnancies, and relationship distress. Some clinicians will consider these issues as part and parcel of an all-inclusive condition they refer to as "sexual addiction," while others will focus on Axis 1 and Axis 2 diagnoses that may be causing risky or destructive sexual behaviors (Kafka, 2010; Moser, 2010). Problematic behaviors that are being driven by a psychological condition such as a personality disorder can be difficult to change until the underlying disorder is successfully treated.

Clinicians with a more conservative orientation may tend to view sexual behaviors that occur outside of traditional or prescribed boundaries as being pathological, while less-conservative clinicians may consider these behaviors within a more global context including cultural influences, upbringing, religious beliefs, and relationship issues. Coleman (2010) cautions that overpathologizing of sexual behavior can occur when the clinician fails to recognize the wide range of normal sexual expression in both variety and frequency. "It is important for clinicians to be comfortable with a wide range of normal sexual behavior, both in types of behaviors and frequency" (Coleman, 2011).

The Problem with Defining Problematic Sexual Behaviors

According to Miner and colleagues (2007, p. 579), compulsive sexual behavior is a clinical syndrome characterized by sexual urges, fantasies, and behaviors that are recurrent, intense, and create a distressing interference in daily functioning. However, not all researchers or therapists interpret the words "create a distressing interference in daily functioning" in the same way. The confusion begins when trying to elucidate which behaviors are perceived as signs of problematic sexuality.

For instance, O'Keefe and colleagues (2009) report that 20.9% of college-aged women in their survey indicated that loneliness can cause them to masturbate.

These researchers expressed concern that less than half of the women who endorsed this item were able to recognize that masturbation due to loneliness is "a sign of sexual addiction or sexual compulsivity" (O'Keefe et al., 2009, pp. 122–123). According to O'Keefe and colleagues, there are correct reasons to masturbate, and loneliness is not one of them. Even more disconcerting is their assertion that therapists need to be concerned about the presence of a paraphilia and/or sex addiction when women use insertive sex toys for masturbation or when they use sex toys with partners. Studies such as these beg the question of whether these behaviors are problematic because they are signs of an actual disorder, or if they clash with the personal, cultural, and religious values of the authors.

Along these lines, it might be helpful to consider some of the questions that are asked in the original Sexual Addiction Screening Test, a popular test for sexual addiction that is used by hundreds of clinicians. Twelve of the 45 questions are as follows (Carnes, Green, & Carnes, 2010, pp. 10–13):

- Have you subscribed or regularly purchased sexually explicit magazines like Playboy or Penthouse?
- Do you hide some of your sexual behaviors from others?
- Do you often find yourself preoccupied with sexual thoughts?
- Do you feel that your sexual behavior is not normal?
- Have you attempted to stop some parts of your sexual activity?
- Do you ever think your sexual desire is stronger than you are?
- Do you ever feel bad about your sexual behavior?
- Has sex (or romantic fantasies) been a way for you to escape your problems?
- Have you purchased services online for erotic purposes (sites for dating, pornography, fantasy, and friend finder)?
- Have you regularly purchased romantic novels or sexually explicit magazines?
- Have you felt the need to discontinue a certain form of sexual activity?
- Does your spouse or significant other(s) ever worry or complain about your sexual behavior?

It almost seems as if these questions are pathologizing behaviors that an individual with a robust sex drive might report. A well-trained sex therapist would not diagnose a patient based solely on responses to these items or even the entire questionnaire. Unfortunately, the seasoned clinician is by now all too familiar with patients—and their spouses—who have already self-diagnosed using this test over the Internet and have concluded that the identified "sex addict" is *the* problem in their relationship, when the situation is sometimes much more complex.

There has also been debate about whether the number of orgasms per week is an indicator of a mental disorder such as sexual addiction or hypersexuality.

Kafka (1997) reported that having seven or more orgasms per week for a period of six months was an important benchmark for hypersexuality in a population of individuals with paraphilic-related disorders. On the other hand, an Internet convenience sampling of 14,396 sexually active younger adults found that 44% of the males and more than 21% of the females surveyed said they have seven or more orgasms a week (Winters et al., 2010).

Rather than being a benchmark of pathology, a higher number of orgasms per week may simply demonstrate that the person's sex drive is higher than average. Such a person is likely to have more sex in general than an individual with an average sex drive, and therefore a higher amount of sexual behavior that is potentially problematic (Winters et al., 2010). Many people with high sex drives experience no social or sexual problems as a result of their desires, while others encounter difficulties. However, it has been suggested that a recipe for problematic sexual behavior is when a person with a high sex drive does not have sufficient outlets for sexual expression (Bancroft & Vukadinovic, 2004; Winters et al., 2010). Also, in a relationship where one partner has a high sex drive and the other partner's is much lower, someone may end up being perceived as pathological, depending on the clinician's ideas about "normal" sexuality and its expression.

Trying to identify and quantify exactly how much of a particular sexual behavior it takes to qualify for a diagnosis of "sexual addiction" or "hypersexuality" or other proposed nomenclature for problematic sexuality is a risky business. Kafka (2011) points to the importance of the training and judgment of the clinician. Unfortunately, the scientific data for making such a diagnosis "remain minimal" (Bancroft, 2008). Many sex therapists who fit Kafka's criteria of being well trained and having good clinical judgment do not agree that a specific disorder that causes problematic sexual behaviors even exists, what the criteria for "diagnosis" should be, or whether or not there is an actual problem.

Is It Defined Differently for Married Versus Single People and for Men Versus Women?

Sexual addiction seems to be defined differently for married people than for those who are single. For instance, when a single soldier visits prostitutes while at ports of call or a single college student has a semester full of one-night stands, we might call this promiscuity. However, clinicians would not necessarily call it a sexual addiction unless the soldier or student is female or is married.

When a woman has a high sex drive and her sexual behavior is more typical of a man's, she and the culture she lives in may be more likely to think of her as having a sexual addiction. Skegg and colleagues (2010) suggested that women whose sexual behaviors were more similar to men's may "believe they are inappropriate for women." The authors said the same might be true for women who are having sex with other women: The women do not believe these relationships are appropriate, and therefore experience them as being

out of control. Self-recrimination is not an unusual consequence when people with traditional beliefs experiment with nontraditional behaviors. When sex occurs outside of prescribed and traditional boundaries, we have a tendency to call such behavior pathological.

There are also situations when partners have an agreement that allows each to have sex with others. These same behaviors could result in a psychiatric diagnosis if there were no agreement. Does the fact that the individuals have an agreement absolve them of being diagnosed as sex addicts? This raises a question that the clinician will often wrestle with when confronting problematic sexual behaviors: Are the behaviors the result of a sexual disorder, of a disorder that is not sexual, or does the situation call for some other kind of clinical or moral judgment?

The Prevalence of Problematic Sexual Behaviors in the General Population

Carnes has been quoted as saying that 6% of the general population suffers from sexual addiction (cited in Black, Kehrberg, Flumerfelt, & Slosser, 1997), while Coleman sets the figure at approximately 5% (1992). However, there have been no published studies to support these figures (Skegg, Rada-Raja, Dickson, & Paul, 2010). The first empirical study to examine the frequency of out-of-control sexual behavior in the general population (Skegg et al., 2010) found a much lower incidence than was suggested by Carnes and Coleman. Skegg and colleagues asked 1,037 men and women from New Zealand, "In the past 12 months, have you had sexual fantasies, urges or behavior that you felt were out of control?" Although 14% of the men and 7% of the women reported having had sexual fantasies, urges or behaviors that they considered out of control during the past year, only 2.8% of the total sample believed that these had interfered with their lives. More significantly, less than 1% of the total sample indicated that their sexual behaviors had interfered with their lives (4 of 474 men and 3 of 466 women).

On a related note, there appears to be little difference in the total amount of sex that most men have regardless of whether they are "normal" or describe themselves as being "sex addicts." Winters and colleagues (2010) were not able to distinguish men who described themselves as sex addicts from those who did not based on the amount of sex they were having. Among the 6,458 males who completed their survey, Winters and colleagues (2010) found no significant group differences for the frequency of masturbation, total partnered sexual activity, or total sexual outlet or orgasms per week and psychological symptoms. The main difference was in the ideal amount of sex that the self-described sex addicts wished they could have. Similarly, Skegg and colleagues (2010) found there was little difference in the overall amount of heterosexual behavior between those men who felt their sexual behaviors had been out of control and those who did not. While there are

certainly exceptions, whatever difference there might be appears to be one of self-perception and ideology rather than at the level of sexual behavior.

Unfortunately, comparing studies of individuals who claim to be sexual addicts can be a methodological nightmare. There is little consistency in the way the studies are conducted and the types of instruments used. There is little consistency in how participants are recruited, yet one can expect different responses from self-diagnosed sex addicts who are recruited through 12-step programs versus those who are recruited through ads in alternative magazines. Although excessive or compulsive masturbation is identified as one of the leading "symptoms" of problematic sexual behaviors or sexual addiction (Bancroft, 2008; Coleman, 2010), the clinicians who write about sexual addiction seldom define terms. For example, most people assume that masturbation means self-pleasuring until orgasm/ejaculation. However, the sex addict may say he is "masturbating" 10 times a day, when he may have been stroking his penis for a few minutes and stopped before orgasm. When studies on sex addiction provide startling "statistics" about compulsive masturbation, we need to wonder if the researchers and the participants were talking about the same thing.

Paraphilic Disorders Versus Sexual Addiction or Hypersexuality Behaviors

Paraphilic disorders involve behaviors that are considered to be sexually deviant in the DSM (APA, 2000). Some of these acts are illegal, others are not, but they are outside the range of normophilic sexual behavior. Although paraphilic disorders are considered to be separate from sex addiction or hypersexuality, it is possible to be diagnosed with both (Kafka, 2010). Some researchers believe that the distinction between paraphilias and sex addiction or hypersexuality is not as great as it might seem (Coleman, 2010; Kafka & Hennen, 2002).

As for the perception that sex addiction is a separate disorder (i.e., from the paraphilias) comprising behaviors that are normal but simply excessive, some of the private treatment centers that specialize in sexual addiction hired public relations firms years ago that may have helped further this idea (Irvine, 1995). Including paraphilic behaviors such as pedophilia and zoophilia within the realm of sex addiction could have made members of the public afraid to embrace the notion that they might be sex addicts. As a result, the public has been left with the perception that sex addiction mostly includes "excessive" normophilic behaviors, such as masturbation, vaginal intercourse, watching porn, and having "online affairs."

In defining excessive sexual behavior, modern psychiatry has adopted a Goldilocks-and-the-Three-Bears approach (Moser, 2010): Too much of a given sex act, and it may be diagnosed as a sexual addiction; too little, and it is diagnosed as "Hypoactive Sexual Desire Disorder." The sweet spot is apparently in the middle, where Goldilocks—or the therapist—says "just

right!" The disorder of hypersexuality that was proposed for inclusion in the DSM-5 may have borrowed inspiration directly from Goldilocks. According to Kafka (2010, p. 392), "Conceptually, Hypoactive Sexual Desire Disorder and Hypersexual Disorder represent the opposite polarities in the frequency distribution of sexual appetitive behavior, including sexual arousal and sexual motivation." Ultimately, the question is, which mental health expert should people invite into their bedrooms to decree what is too little, what is too much, and what is just right?

An Historical Perspective on Sex Addiction or Excessive Sexual Behaviors

It can be helpful to consider how the various terms for problematic sexual behaviors, such as "sexual addiction," have been conceptualized historically and whether the current conceptualization even existed previously. The concept of sexual addiction was first put forth in the mid-1970s by a member of Alcoholics Anonymous who believed that his frequent masturbation, his mistress, and other sexual proclivities were the result of a disease that he named "sex and love addiction" (Levine & Troiden, 1988). Carnes (1983) was among the first professionals to publish on sexual addiction, which he described as "a form of insanity," "progressive insanity," and "athletes foot of the mind."

Many authors cite nymphomania, satyriasis, and Don Juanism as historical precedents for sexual addiction (Kafka, 2010; Levine & Troiden, 1988). It can be misleading to assume that behaviors that were described as excessive in the past would be considered excessive at present. To provide historical moorings for the recently proposed psychiatric disorder of hypersexuality, Kafka (2010) states that one of America's founding fathers and most famous physicians, Benjamin Rush, had documented "excessive" sexual behaviors two centuries ago. However, Rush (1835) helped propagate the idea that even small amounts of masturbation result in "seminal weakness, impotence, dysury, tabes dorsalis, pulmonary consumption, dyspepsia, dimness of sight, vertigo, epilepsy, hypochondriasis, loss of memory, manalgia, fatuity, and death" (Rush, 1835, pp. 31, 345). Kafka (2010, p. 378) also cites Richard von Krafft-Ebing (1894), who wrote that masturbation "exhausts the source of all noble and ideal sentiments" and "despoils the unfolding bud of perfume and beauty." It is unlikely that Kafka would agree with Rush or Krafft-Ebing's notions concerning masturbation, even though he cites them in his historical overview of excessive sexual behaviors.

A frequent criterion for the diagnosis of sexual addiction is paying for sex. Yet in the late 1800s, brothels were located on almost every downtown street in every city in America (Gilfoyle, 1994; Rosen, 1983). Men, whether married or single, often formed long lines for their turns to pay for sex in these brothels. It has only been recently that paying for sex has become a criterion for a psychiatric diagnosis. While these behaviors are hardly new, designating them as pathological is a recent development.

As for the relevance of nymphomania, many current, sexually active, young women would have been diagnosed with nymphomania had they magically awoken in the year 1940 or 1950. Rather than being an actual disorder, the diagnosis of nymphomania was psychiatry's way of condemning single women who enjoyed sex as much as men did, or married women who enjoyed sex with men other than their husbands. Sexual addiction and hypersexuality are only similar to nymphomania when they are being used to stigmatize a woman for having a high sex drive and acting upon it in ways that a man might with impunity.

One of the key elements that surfaces in many of the papers written about sexual addiction is the excessive use of Internet pornography (Bancroft, 2008; Coleman et al., 2003; Cooper, 2002), regardless of any agreement by clinicians or researchers on what "excessive use of Internet pornography" might be. It is unlikely that the construct of sexual addiction would have nearly as much traction as it does at present without the crucial feature of Internet pornography, which did not exist in its present form until the late 1990s.

The way we define sexual addiction, hypersexuality, and other related constructs as mental disorders make them recent phenomena with little historical precedent.

The Contemporary Cultural Backdrop of Sexual Addiction

Irvine (1995) believes that mental health professionals have created a new medical disorder called "sexual addiction" in an attempt to transform a social problem into a medical problem. To do this, they have needed to drop the idea that an abused substance is required to have an addiction. They have replaced the substance with the sickness or badness of uncontrollable sex. The term *addiction* provides a certain moral neutrality for the sex addict, and it offers the excuse of "having a disease." From Irvine's perspective (1995), the "sex addict" is a character constructed from the social ambivalence of the current era.

It is significant that there are 12-step programs and in-patient treatment centers to help cure people when they watch pornography at the expense of being with loved ones. However, we do not have 12-step programs and treatment centers for individuals who watch sports or listen to talk-radio for hours on end at the expense of being with loved ones. Sex addicts are said to use sex to regulate their moods and negative emotions (Carnes, 1983). People use their work or hobbies for regulating their moods and negative emotions, and there are no diagnosable illnesses for such conduct. Many individuals focus on their careers at the expense of their relationships. They and their partners may feel distressed as a result, yet there is no diagnosis for that, either (Winters, 2010). Nor is it designated an addiction when people use antidepressants to regulate their moods and negative emotions. It is said that sexual behavior is a sign of addiction when it results in harm to oneself or to others. Yet we do not say the same for people who ride motorcycles, jump out of airplanes, or volunteer

for the military during time of war. The problem is not with causing harm to oneself or others unless sex is part of the equation, thus calling the objectivity of the diagnostic process itself into question (White, 2006).

Bancroft et al. (2004) and Winters and colleagues (2010) found that a significant number of people who described themselves as sex addicts or who had received treatment for sexual addiction had strong religious beliefs. (The participants' religions were not identified.) Someone who has strong religious beliefs might describe himself or herself as a sex addict, when another person who has similar sexual behaviors would not think anything of the kind.

One of the dominant themes of some Christian denominations is the idea that God will remove the stain from the sinner's soul and make the person feel clean again. At the same time, the term *dirty* is commonly used to describe things that are sexually arousing, such as "dirty books," "dirty thoughts," and "dirty deeds." This puts the dirty or titillating parts of sex on a collision course with the beliefs of some religions. When that is the case, it creates the necessity for these religions to structure beliefs about sexuality in a way that makes sex feel clean or at least neutral for its followers. The idea of only allowing sex within the sanctity of marriage and for the purpose of reproduction can be an important step in accomplishing this goal. This way, sex can be framed in a spiritual sense, as something that is uniquely special between husband and wife.

Masturbation and pornography speak solely to the pleasurable aspects of sexuality as opposed to the sacred role that some religions believe sex should play between husband and wife. These acts remove the veil of legitimacy and make sex "dirty" again. The conservative religious believer who masturbates or watches pornography can be left feeling shame and self-loathing as a result. The self-perception of being a sex addict may therefore come more easily to an individual who is steeped in particular conservative religious beliefs about sex.

Approach, Withdrawal, and Out-of-Control Sexual Behaviors

Bancroft and his colleagues (1999) proposed that human sexual response is controlled by two independent systems: sexual excitation (for approach) and inhibition (for avoidance or withdrawal).When most people encounter a situation that is sexually exciting, they will respond by becoming aroused and wanting to approach. However, when they do not feel safe or if they sense there will be negative consequences (e.g., pregnancy, disease, spousal retribution), they inhibit their sexual responses. In testing this hypothesis, Janssen and colleagues (2002) found that people who scored higher on sexual excitement scales tended to have sex more often in real life, while those who scored higher on sexual inhibition scales tended to have less sex in real life.

What does this have to do with problematic sexual behaviors? Common sense suggests that people should be able to inhibit or throttle back on their sexual excitement in situations where acting upon it would be problematic or might endanger their relationships. Conversely, when it is appropriate to have

sex, they should be able to decrease their inhibition and be able to act upon their sexual excitement. Individuals who struggle with problematic sexuality may have trouble inhibiting their sexual excitement in risky situations, perhaps because they do not recognize that the situation is risky, or because they actually become more aroused rather than less as a result of trying to inhibit their excitement.

Winters, Christoff, & Gorzalka (2009) asked male participants to inhibit their sexual arousal while they were being shown sexually arousing videos. Penile plethysmography was used to determine the level of success. Although some of the men proved to be quite adept at regulating their sexual arousal, the opposite proved to be the case with others who actually became more sexually aroused while they were consciously trying to inhibit their responses. This was particularly true for men who demonstrated higher levels of sexual excitement from the outset. For some men, the mere act of trying to suppress exciting thoughts appears to have the paradoxical effect of increasing sexual desire (Winters et al., 2009). Imagine the frustration that these men might have when trying to limit their sexual behaviors and the opposite results occur.

Mood and Sexual Dysregulation

When most people are depressed or anxious, they are less inclined to want sex. However, there is a small group of individuals who do just the opposite: When they are anxious or depressed, they want more sex (Apfelbaum, 2011). To study this further, Bancroft, Janssen, Strong, & Vukadinovic (2003, pp. 232–233) and Bancroft et al. (2003b) developed a questionnaire that asks, "When you have felt depressed (or anxious/stressed), what typically happens to your sexual interest or response?" Although most people in a nonclinical sample answered that their sexual interest decreases when they are anxious or depressed, approximately 10% reported increased sexual interest when they are depressed. Approximately 20% said they have increased sexual interest when they are anxious or under stress (Bancroft, 2008). Of the 20% whose sexual interest increased when anxious or stressed, masturbation was the preferred sexual outlet.

When Bancroft and his colleagues gave this questionnaire to a small group of self-identified sex addicts, 17 of 32 participants said they were more likely to act out sexually when they are depressed, and 19 of 32 said they were more likely to act out sexually when they are anxious or stressed. At more than 50% for each category, this is considerably higher than the 10% to 20% for the general population. Not only did this group of self-identified sex addicts report that they were more likely to increase their sexual behaviors when depressed, anxious, or stressed, but they were more prone to feel depressed than the controls (Bancroft et al., 2004). On the other hand, it is possible that sex addicts who had taken part in 12-step programs believed there is a connection between problematic sexual behaviors and anxiety, depression, or stress because this belief is one of the cornerstones of 12-step programs.

In fact, Bancroft is quick to caution that his data do not necessarily support the 12-step ideology that "sex addicts" use sex to help regulate their depression, anxiety, or stress. People who remain sexually interested when they are depressed might be utilizing sex as a way of making emotional or physical contact that is needed badly, as is often the case for drug addicts who attend frequent 12-step meetings (Bancroft, 2008). Having sex might help the individual feel validated or desired, which is not the same as using sex to regulate a negative mood (Bancroft, 2008). Sexual stimulation might also be a form of distraction that helps keep individuals from thinking about things that make them feel depressed. Psychologically speaking, this can be an adaptive mechanism. It is very different from using alcohol or drugs to help deaden the pain that results from negative moods.

As for the relationship of depression and anxiety with problematic sexual behavior, antidepressants, which are used to treat depression and anxiety, have shown some success in some patients in decreasing the frequency of problematic sexual behavior (Coleman, 2010). However, these drugs also have the side effect of decreasing the libido. It is not known whether the limited impact of these drugs on problematic sexual behaviors is due to their effect on depression and anxiety, or because they are lowering sexual desire in general.

Sexual Desire Discrepancies

Most sex therapists deal extensively with sexual desire discrepancy. A possible solution for the partner with the higher drive might be to masturbate frequently, perhaps with the aid of pornography. But what if masturbation is against the person's religion, or his/her partner finds it to be offensive? Given the constraints of the situation, such an individual may experience distress in trying to manage sexual urges, fantasies, and behaviors (Winters et al., 2007). The individual might be "normal," but when paired with a partner who has a lower sex drive, he or she might feel like a sex addict, and the partner might accuse him or her of being that as well.

Another issue is when orgasms fail to provide relief. Most people find that orgasms usually provide relief from erotic tension and sexual urgency. However, orgasm does not provide satisfactory relief in some men and women. This may cause them to feel insatiable and in need of more sex. Curiously, some women who are frequently aroused but who get little relief from orgasm are described as having Persistent Genital Arousal Disorder (Leiblum, Brown, & Wan, 2005). Little is known about this phenomenon or these phenomena.

Childhood Sexual Abuse and Problematic Sexual Behaviors

Many people assume that childhood sexual abuse (CSA) is a cause of sexual addiction. The first question on the Sexual Addiction Screening Test is "Were you sexually abused as a child or adolescent?" (Carnes et al., 2010, pp. 10–13). Coleman and others have postulated a relationship between CSA and sexual

compulsion or sexual addiction in adults (Coleman, 2010; Maltz & Maltz, 2010). If there were a direct relationship between CSA and problematic sexual behaviors, there should be as many sex addicts who are women as men, if not more. However, in his review of the literature on sexual addiction, sexual compulsivity, and hypersexuality, Kafka (2010) concludes that there are at least five times as many men as women reporting problematic sexual behaviors. This finding may suggest a fundamental flaw in our understanding of "sex addiction" and its relationship to CSA.

Although CSA has not reached significance in studies of female sex addicts, it has been related to problematic sexual behaviors in some studies of men (Skegg et al., 2010). In their study of self-described sex addicts, Bancroft and colleagues (2004) unexpectedly discovered that 14 of 23 (45%) participants used terms to describe sexual arousal that were suggestive of dissociation. These terms included *trancelike*, *numb*, *zoning out*, and *not conscious of reality*. Dissociation is frequently associated with CSA, although Bancroft and colleagues did not link dissociation during sex in adult men to CSA.

Closing Thoughts and Diagnostic Considerations

Patients and their therapists face many challenges in trying to conceptualize problematic sexual behaviors. It would be a very unusual patient who arrives in a clinician's office and says, "I think I have dysregulated sexuality." Instead, the word "sex addict" is often used. When a patient reports being a sex addict, we cannot assume that it reveals anything more than a concern about something related to sex. It tells us nothing about how the person regards normophilic sexual behaviors, whether the problem can be solved with basic sex education, whether guilt and shame are involved, or if deeper psychological factors are involved.

The clinician will want to explore some of the following: Are the thoughts, feelings, urges or behaviors that are causing distress the result of sexual incompatibility with a partner? To what extent are personal or religious values at play? How does the person describe intimate relationships? Is there an inability to have sex when emotional intimacy is involved? Is the root of the problem a discrepancy in sexual desire frequency between partners who are otherwise well matched? Is the patient involved in a mismatched relationship and needs help in the process of separation? What is the severity of stressors in the person's life and his or her level of functioning? Have there been problems with drug or alcohol use? If underlying pathology is suspected, is there depression, anxiety, a personality disorder, a mood disorder, psychosis, trauma from childhood, traumatic brain injury, or other Axis 1, Axis 2, or Axis 3 factors?

One of the many challenges for the therapist is the lack of clinically validated instruments to measure sexual addiction, compulsive sexuality, hypersexuality, or whatever terms are being used to describe problematic sexual behaviors

(Coleman, 2010). In addition, there is no checklist that can inform the clinician whether sexual behavior is normative or a symptom of underlying pathology.

Just because sexual behavior is problematic does not mean that it is pathological. "Problematic sexual behavior is often remedied by time, experience, education or brief counseling" (Coleman, 2011). On the other hand, troublesome sexual behaviors that are symptomatic of a psychological condition and are being driven by it (e.g., a personality disorder) can be difficult to treat effectively until the underlying disorder is successfully treated.

Even the most accepting of therapists will see patients with sexual behaviors that are truly problematic. The challenges for the clinician can be difficult and will require a wide range of assessment, conceptual, and therapeutic skills.

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