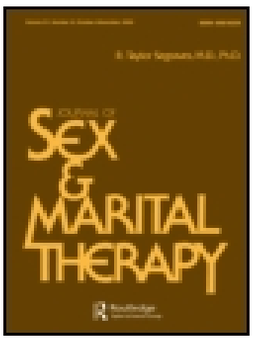

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What is Sexual Addiction?

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Married men labeled as sexual addicts *seek help after being discovered to have had broken monogamy rules for sexual behavior through their use of masturbation, pornography, cybersex, commercial sex involvement, paraphilic pursuits, or affairs. This study analyzed the sexual patterns and dynamics of 30 men who presented to 1 clinician between 2005 and 2009. Their important differences were captured by a 6-category spectrum: (a) no sexual excess beyond breaking the spouse's restrictive rules (*n = *2), (b) discovery of husband's longstanding sexual secrets (*n = *5), (c) new discovery of the joys of commercial sex (*n = *4), (d) the bizarre or paraphilic (*n = *7), (e) alternate concept of normal masculinity (*n = *5), and (f) spiraling psychological deterioration (*n = *7). Only the men with a spiraling psychological deterioration—about 25% of the sample with sexual issues—could reasonably be described as having a sexual addiction. This group experienced significant psychological failures before the onset of their deterioration. Another 25% were adequately defined as* paraphilic. *Half of the sample was not adequately described using addiction, compulsivity, impulsivity, and relationship incapacity models. The authors discuss the implications of these findings for DSM-5 and treatment.*

In the 19th century, the labels *moral insanity*, *satyriasis*, and *nymphomania* were applied to people who lost control over their sexual behaviors. Today, the term *sexual addiction* serves the same overarching purpose. Carnes suggested this term in 1983 well before the explosive growth of Internet technologies (Carnes, 2001). The Internet offers even more possibilities for devotion to sexual pleasures through ready access to pornography and prostitution services, chatting with people who have similar sexual interests and concerns, and playing erotic games. These new cultural opportunities

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remind clinicians of the alluring power of relationless sexual stimulation. Many human beings like these forms of sexual stimulation so much that there is new uncertainty about the rules for conducting sexual life during courtship and marriage (Skegg, Nada-Raja, Dickson, & Paul, 2009).

Sexual addiction is a confusing topic. It routinely stimulates much negative judgment because its patterns frequently involve betrayal, illuminate previously hidden sexual behaviors, expose unsuspecting partners to disease risk, and threaten partners with abandonment (Dodge, Reece, Cole, & Sandfort, 2004). Professionals cannot be sure when it should be dealt with as a separate category of behavioral disorder, as a symptom of an underlying problem, or as a choice reflecting personal sensibilities. Diagnostic and Statistical Manual (DSM) committees have not yet found sufficient reason to designate sexual addiction as a psychiatric disorder, perhaps because the limits of sexual normality are not clearly defined, the symptom patterns are not distinct, intense moral judgments are involved and the label may be a misnomer.

There are numerous ways that sexual expression can be excessive, problematic, or out of control in men and women (Turner, 2008). Consider these terms: Don Juanism, erotic obsession, erotomania, hedonism, hypersexuality, loss of control of sexual behavior, love addiction, moral insanity, nonparaphilic compulsivity, nymphomania, paraphilia-related disorder, paraphilic compulsivity, persistent genital arousal disorder, problematic hypersexuality, promiscuity, satyriasis, sexual compulsivity, sexual excess, sexual dependence, sexual impulsivity and sexual obsession. All 21 of these labels connote a violation of social and developmental norms.

Conventional society expects adults to manage their sexual behavior within certain limits and parameters. These expectations form largely unwritten rules that protect and support the institution of marriage, preserve the dignity and health of the partner who expects monogamy, and shield children from the risks of family breakup and skepticism about love. These expectations explain why the sexual behaviors in question are thought of by laypersons as immoral, immature, or sick. Rules apply to unmarried individuals as well, but considerable more sexual leeway is given to single men and women than to those who have committed themselves to a partner. Rules are not just socially dictated by cultural mores, however. Heterosexual, gay, lesbian, or transsexual couples explicitly or implicitly define the boundaries for their sexual behaviors involving masturbation, pornography use, strip club attendance, massage parlors, and other partners.

Sexual Addiction is a Behavioral Complex Not a Diagnosis

The clinical perception of sexual addiction is based on behaviors that are obviously destructive to somebody—the person himself or herself, the spouse, lover, family, employer, or society (Goodman, 2001). These behaviors may

occur at a high frequency or occupy a large amount of time. They are sometimes expensive in economic, psychologic, and social terms. They may persist despite negative consequences. The patient may not be able to stop the behavior when he or she states that goal. Most of the behaviors are kept a secret, although some partners know about their presence but not their extent.

When such conditions are met, clinicians often respond as though the patient has met criteria for a distinct disorder. Three questions arise: (a) Are these criteria sufficient for a distinct disorder? (b) Do these criteria demarcate a clear zone of difference between the behavior in question and sexual normality? and (c) Do these criteria demarcate a clear zone of difference between sexual addiction and another known sexual disorder? Clinicians who offer treatment for the patient's sexual addiction may be paying insufficient attention to growing concerns about the significant limitations of psychiatric diagnoses that the head of the Diagnostic and Statistical Manual-V (DSM-V) effort recently articulated (Kendell & Jablensky, 2003; Regier, Narrow, Kuhl, & Kupfer, 2009). These concerns are not bypassed by finding high scores on a sexual addiction questionnaire (Kalichman & Rompa, 2001).

Whatever the concerns about the validity of the concept of sexual addiction, the diagnosis is well rooted in the public's mind and has seeming clarity for individuals and institutions that provide treatment. The concept, therefore, is useful for several purposes. The ultimate goal of this discussion about the validity of the concept is to improve treatment effectiveness.

Labels and Meanings

The first clinical limitation of the concept of sexual addiction stems from realizing that the term *addiction* conveys the impression that their essence is an addictive psychopathology. Similarly, the terms sexual *impulsivity* and sexual *compulsivity* suggest a different mechanism of production of these behaviors. Two decades ago, M. P. Levine and Troiden (1998) warned that such terms create clinical illusions.

Is sexual addiction related to drug addiction?

Drug addiction is a chronic, relapsing disorder in which drug-seeking and drug-taking behavior persists despite serious negative consequences. Addictive substances, such as opiods or nicotine, induce pleasant states (euphoria in the initiation phase) or relieve distress. Continued use induces adaptive changes in the central nervous system that lead to tolerance, physical dependence, sensitization, craving, and relapse. Much fruitful scientific and therapeutic work has been accomplished on the neurophysiology of drug addiction, substance craving, and the reward pathways of the brain. Whether

alcohol, cocaine, or tobacco (romantic and maternal love as well) is the topic, studies point to pathways connecting the ventral tegmental area and nucleus accumbens, such as the medial forebrain bundle and connections between the limbic system and cortex. The major neurotransmitter of reward is dopamine, and the location is a mesolimbic pathway (Bartels, 2004).

Sex addiction is said to be a chronic, relapsing disorder in which repeated sexual stimulation persists despite serious negative consequences. Sexual arousal induces pleasant states (euphoria in the initial phase) and relieves stress. Dependence, craving, and relapse frequently exist (Delmonica, 1999). It is not known whether continued excessive sexual stimulation induces central nervous system changes. It does not seem to be a large leap to assume that the dopaminergic reward pathways are involved; however, there are no studies of this topic. Many patients that clinicians perceive as sexual addicts seem to be dependent on sexual stimulation. The term can be used to imply that sexual stimulation acts like a drug on the nervous system and is dangerous to otherwise normal persons in the same way as is heroin. It also can be used to imply that the person has an addictive personality; sex just happens to be the current medium that manifests it. The term has limitations conceptually, psychometrically (Reid & Carpenter, 2009), and, as we shall see, clinically.

Many of our life's defining activities are colloquially referred to as *addictions*. There is a considerable uneasiness about assuming that other activities that we give into, become compelled to continue, and unbalance our lives for are addictions. We may refer to day trading stocks, gambling, working, shopping, excess eating, self-induced starvation, collecting things, gardening, playing games or sports, exercising, watching television or movies, reading, praying, e-mailing, and writing professional papers as *addictions*. Having a strong interest in sexual pleasure throughout life could not be the essence of sexual addiction because it is often regarded as a sign of mental health.

If DSM-V uses the label sexual addiction, soon clinicians will be reading that it is a brain-based disease rooted in some inherent neurophysiologic vulnerability that operates through dopaminergic surges. Maybe this is exactly why some people buy another pair of shoes. Even if drug addiction is considered only as an analogy (for instance, pornography is considered a *drug of choice*), or if a large number of patients are also drug-dependent, clinicians can still be committed to seeking a better understanding of the origins of the problem.

Is sexual addiction a form of an impulse control disorder?

The impulsive are said to be risk takers who seek pleasure and quick gratification. They do not think about the consequences to themselves and to others until after the behavior has been engaged in (Brewer, 2008). When

guilt appears, it follows the act. Young people are often thought to become less impulsive in their sexual expressions as they mature. Labeling a person in this way implies that the clinician thinks that the patient does not plan or carefully consider his or her sexual behaviors and is relatively helpless to decline an opportunity for sexual gratification.

Is sexual addiction a variety of compulsive disorder?

Researchers sometime refer to an *obsessive-compulsive pattern* or just to *sexual compulsivity* (Cooper, 1998). In general, obsessive-compulsive people are said to be harm avoidant, risk avoidant, and seeking to reduce their anxiety but their methods do not work and they have to endlessly engage in them. Clinicians commonly use the term to convey the patient's subjective sense of drivenness that results in little constraint in gratifying themselves (Raymond, 2003). Particularly, in HIV studies, the term has become a synonym for large numbers of partners rather than a description of the motives or mechanisms (Kalichman, 2001). Obsessive-compulsive disorder is rarely associated with patterns being discussed here.

Is sexual addiction a relationship disorder?

This idea locates the source of the problem at a person-to-person level. The origins are thought to derive from child-parental processes or object-relating capacities. Current relationship problems such as the angry sexual unavailability of the partner is seen as a consequence of the patient's fundamental incapacity to allow the self to be known intimately by another (Marcus, 2010). Severely developmentally handicapped men, lonely and frustrated in their attempts to create relational sexual lives, might be considered as belonging to this category.

All of these comparative terms by implication characterize the mechanism by which individuals engage in problematic behaviors. This study was undertaken to reconsider the aptness of these comparisons and their implications to better define what is and what is not a sexual addiction.

METHODS

A retrospective chart review was undertaken of men who sought help from the author during the past 5 years for what they or the referral source labeled as *sexual addiction*. Thirty men were identified. Cases evaluated by other clinicians at our Center, men who have been discovered to be having a new extramarital sexual affair, and those who presented with a paraphilia were excluded. The men ranged in age from 26 to 79 years. The selection bias

was toward those who could initially afford private psychiatric care without total dependence on insurance reimbursement. The educational level was high. Twenty-six patients were married, two were divorced, and two were single. Twenty-five were fathers. Twenty-eight were Caucasian. All but one was heterosexual; one identified as bisexual.

Cases were extracted to produce vignettes that captured the essence of the presentation. Then they were arranged on a spectrum and arbitrarily divided according to perceived essential similarities.

RESULTS

The spectrum of behaviors, dynamics, and circumstances discerned in the case series lent itself to six subdivisions (see Figure 1). Twenty-eight of the cases were strongly emblematic of their subdivision despite the fact that many of these cases superficially share characteristics of Subdivisions 2–6. A full description of the 30 cases is available from the author.

Subdivision 1. No sexual excess beyond breaking the spouse's restrictive rules—n = 2.
Subdivision 2. Discovery of husband's longstanding sexual secrets—n = 5.
Subdivision 3. New discovery of the joys of commercial or chat room sex—n = 4.
Subdivision 4. The bizarre or paraphilic—n = 7.
Subdivision 5. A different concept of masculinity—n = 5.
Subdivision 6. Spiraling deteriorating dependence of commercial or illegal sex—n = 7.

FIGURE 1 The spectrum of patterns among 30 men presenting with sexual addiction.

Subdivision 1: No sexual excess beyond breaking the spouse's restrictive rules

Two cases were found that represented a spouse's erroneous categorization of the problem as excessive. Adam's case was a benign misunderstanding; the motive for the other case was to find a pretense to divorce a husband.

> Adam—While her schizophrenic mother was slowly dying of pancreatic cancer, an exhausted college professor discovered her quiet husband looking at adult heterosexual pornography. Shocked by this discovery, she threatened to divorce him for his infidelity. At her next weekly session with her therapist, the therapist suggested that her husband was likely a sexual addict who needed help. The facts seemed to be, however, that she discovered his second episode in 2 months of masturbating using pornographic material found on the Internet. He and his wife reported a mutually satisfying sexual relationship for 38 years, which had recently become less frequent because of the mother's physical deterioration. He had no other extra dyadic sexual behaviors or interests. After having one

session with the wife after her mother's death, her diagnosis of sexual addiction was abandoned, and the threat of separation dissipated.

Subdivision 2: Discovery of husband's longstanding sexual secrets

The five cases who fall under this subdivision were characterized by longstanding, ego-syntonic, self-serving sexual behaviors. The men claimed that they did not think much about their motives. Shortly after evaluation, 3 of the men happily returned to more conventional marital sexual opportunities after dealing effectively with their narcissistic assumptions about their rights to be with, in some fashion, other women.

> Curtis—A happily married stockbroker, father of three children, was discovered by his wife to have purchased sensual massages monthly for years along with his more frequent standard massages. His satisfying twice-weekly marital sexual life was also secretly supplemented by masturbation to pornography several times per week. Perhaps four times per year he visited a strip club with customers or with male family members. He considered himself faithful because he never engaged in intercourse. He viewed his sensual massages as a variant of masturbation. Before her discovery, his wife used to tell him that he always thought of himself first and always found a way to do what he wants. Not particularly an insightful or thoughtful person, in individual psychotherapy, Curtis quickly had a surge of understanding of his wife's viewpoint and of her profound distress. He began to refer to himself as immature and self-centered. He committed himself to growing up. He and his wife began having sex four times per week, and he invested himself in understanding the waves of distress his wife felt for months after her discovery. He ceased masturbating to pornography.

Two other men in this category were unable to have sex with their receptive wives despite extensive therapy. Both have severe situational hypoactive sexual desire disorder. One was a 79-year-old man who has frequented prostitutes for 60 years. He was sexually involved with his two wives only during courtship. His pattern seemed to stem from his problematic relationship with his mother. The other case's decades of masturbation and sexual avoidance of his wife seemed to stem from his previous marriage to a woman who deteriorated into an opiod-dependent nonfunctional person shortly after marriage.

Subdivision 3: New discovery of the joys of commercial or chat room sex

Of the 4 men who fell into this subdivision, 3 had long been faithfully married until they had an encounter in the commercial sex world that changed their lives and provided them with something that they had long felt had been missing. The term *infidelity* seemed to better describe their behaviors than

did the term *sexual addiction*, although each felt a dramatic pull toward their secret partners, which they labeled as "I'm addicted." The conjoint therapy of one of these cases has been published (S. Levine, 2006).

> Graham—Graham is a 51-year-old international lawyer who liked the best of everything. His life changed when having learned of an exclusive house of prostitution in a foreign capital, he spent $2,000 in one night and was surrounded by beautiful, sexually available women in a luxurious, quiet, and discreet setting with fine food and alcohol. The experience led to a new active exploration of similar ones in the various places to which he traveled. After about a dozen experiences over 2 years, his wife commented on his sexual disinterest and new enthusiasm for being away. She pressed him into a confession. He told me, "I'm addicted to this. I love this. I can't do this any more and expect to be married. My wife is a wonderful person; our family is great." During a 3-month psychotherapy, he sadly gave up his exciting life and concentrated instead on returning to playing a musical instrument, a hobby that he had abandoned when he was in law school.

Subdivision 4: The bizarre or paraphilic

This portion of the spectrum contains a group of patterns that have been manifested since at least adolescence and tend to be highly unusual in their form. Most of these seven cases are clear paraphilias; all convey a profound sense of the limitation in relating to others in a conventional loving way. Those who are married have long been sexual disappointments to their wives.

> Jack—Jack, a 56-year-old married man on disability for Bipolar I disorder, was referred by his psychiatrist of 3 years when the patient told him about his sexual pattern of paying women for the opportunity to perform cunnilingus on them. He boasted to his doctor that he was a world-class provider of this service. The doctor told him he was a sex addict with a narcissistic personality disorder who needed a specialist. The patient was happy with the referral because when the sex was discussed, the doctor's face flushed. Once, the doctor told the patient that his infidelity was "highly immoral." The patient spent his young-adult years driven to sexual excesses, primarily through constant, brief, sexual encounters and multiple masturbatory experiences daily. However, age and medication have dampened his libido. His wife refuses to be sexual with him because of his numerous infidelities. She has no interest in what he does in this arena. For more than a decade, he has pursued his interest three to five times a month. He often did not have orgasm with the woman.
>
> Keith—Keith is a 47-year-old happily married childless man who lost his lucrative key-man job when he was discovered to have placed a camera under a desk in the hopes of recording images of a particular woman's

> covered perineum. Long fascinated by the panties of older women, Keith was never able to consummate his marriage. Being an alpha male all of his life, he never would consummate any of the many female sexual partners requests for intercourse. He and his sister were incest victims.

I have found that the recognition of the unique sexual adaptations of these paraphilic men to be more helpful in understanding and helping them than the term *sexual addiction*. Paraphilic men can initially appear to be quite socially deteriorated, and most have a significant sexual dysfunction but their paraphilic patterns are largely stable.

Subdivision 5: A different concept of masculinity

Some men believe in adult entertainment, socialize in strip clubs, and woo their customers by buying them evenings of the same. They love this environment; they think that most men in their line of work also similarly enjoy these nights out—particularly when they are free to them. They feel entitled to this fun and feel they are behaving normally for a man. This male privilege is part of their identity. Hard drinking, attendance at professional sports events, strip clubs, lap dances, and pornography are integral to their values. They have a separate concept of fidelity from their partners. These men generally function quite well in their work environments but drink heavily outside of work. Four men in this series fit this description, although many others seemed to more subtly share this value system. When these men are referred to as *sex addicts*, it may be difficult for clinicians to think of them as having a disorder when they articulate how many men in their circle think as they do. When scholars describe how men have thought about sexual pleasures outside of marriage for thousands of years, it becomes more difficult to label the men as having a sexual addiction (Squires, 2008).

> Quentin—Quentin runs a successful niche construction business in several states. He and his crew are gone several nights per week most weeks. He not only sells the jobs but also supervises their construction and provides skilled labor as needed. His wife of 30 years now thinks he is a sex addict, a pervert, and an alcoholic (he has had three citations for driving under the influence and jail time for it). He claims that he is faithful because he has never had sex with another woman. He often has sex with his wife after his nights out. "I like to drink and I like strip clubs; so do most of the men I know."

Subdivision 6: Spiraling deteriorating dependence of commercial or illegal sex

Seven men were encountered whose lives have been spiraling downward into a state of vocational and social deterioration. They used commercial

sex—pornography, lap dances, or prostitution, and Internet trolling for sex to soothe their troubled lives. An important personal failure typically triggered the deterioration, but its nature and attendant feelings were obscured by their constant sexual stimulation. The most common sources of failure were the recognition that a wife was deeply unhappy in the marriage or a job failure. They often have a history of other addictive behaviors before the sexual loss of control. Of these 7 men, 2 developed paraphilic preoccupations in adulthood without previous adolescent history of paraphilia. The new paraphilic preoccupations were attempts to embrace their self-loathing. All of these men depend on impersonal sex to temporarily comfort and distract themselves from their considerable mental distress. Their situation only briefly improved by their sex acts.

Their use of commercial or Internet sex readily creates a sense that they use these outlets as alcoholics use spirits. As with many alcoholics, it is easy for clinicians to focus on the addictive pattern rather than what it was a response to originally. Regardless of their individual failures, the men seem to have suffered additional negative consequences from their self-soothing with the sexual activity.

> Ulrich—Ulrich was a loving, faithful husband and father who sought couples' therapy in his thirties for his wife's lack of sexual desire. Despite many interventions over many years, no significant change occurred in their sexual lives other than he lost the ability to ejaculate in his early forties and he discovered the Internet. He began surreptitiously drinking, gained much weight, collected a vast amount of pornography, allowed his business to falter, and eventually was arrested for downloading child pornography. His legal problems led to his being registered as a sex offender. When he was discovered to have violated his parole, it became clear that he also had a longstanding girlfriend. Jail, loss of his business, alienation from his family, and divorce ensued.

> Victor—Victor, a former LSD, marijuana, and cocaine user in his teens and twenties and an alcoholic in his thirties, was treated for Bipolar I disorder in his fifties. Victor inherited a great deal of money at the same time his highly successful seminar leading became passé. Unemployed and not certain that he wished to work, he became depressed and lost interest in his educated wife. He coped with her complaints about his inertia and withdrawal from the family by entertaining himself with pornography and strip clubs. When she wanted a divorce, he suddenly had great sexual desire for her. As she persisted in her unhappiness with him, his spending on commercial sexual activities escalated. When the divorce process was underway, he became suicidal. A year after his divorce, he overcome his strip club attendance and pornography use by becoming referred to as a *sugar daddy* to a stripper 26 years younger than he. "I support her financially, and she ends my intense loneliness." This soon morphed into his attempt to rescue her from her heroin addiction, drug dealing, and

inadequate mothering. The sex that occurred at the beginning of their relationship diminished dramatically as he discovered the person behind the exciting role of stripper. "I know I am a fool, but I am crazy jealous of the possibility that she will return to lap dancing and do other men like she did me."

Yuri—Yuri is a 30-year-old attorney who could not overcome his diffidence about asking girls out. After law school, separated from his group of friends, he failed at creating a social life. He relied on the Internet pornography, but as he felt progressively more of a failure each year, he began exploring pornographic scenes with progressively younger women and teenagers. He happened to overhear a couple having sex in a ground-floor apartment and began to audiotape their frequent nocturnal activities. He was arrested when the couple discovered the tape recorder. A police search of the hard drive of his computer revealed thousands of pornographic images, including many of children. He was briefly imprisoned.

DISCUSSION

This impressionistic retrospective presentation of 30 cases has significant limitations. It represents one author's perceptions over a 5-year period. The sample is highly skewed to heterosexual, educated White men. Younger, gay, bisexual, less-educated, and less-affluent men seen in different healthcare settings likely would demonstrate different patterns. Because selection bias is present in every setting, generalizations about these problems should be made cautiously.

Of these men, 28 have violated the publicly endorsed conservative norm of monogamy, which insists on no designed, chosen, repeated sexual excitement with another real or virtual person. This analysis, as other case series before it, illuminated that the violations were varied, motivations were diverse, and associated emotional problems were wide ranging (Black, 1997; Finlayson, Sealy, & Martin, 2001; Reid & Carpenter, 2009). Many of the men in this series occupied elevated positions in their vocations. All of the married men initially represented themselves as endorsing conventional norms to their wives. Such endorsement may be required for the perception of sexual addiction; men who reject these values might scoff at the idea that they have an addiction as did one man after a month of coerced residential treatment. "My use of the Internet to procure sexual partners was my carefully considered choice. Don't try to make me into a sick person just because you don't like my pleasures with other women!" He filed for divorce.

The recognition of the wide spectrum of patterns found among these men can assist clinicians in clarifying what is best not defined as sexual addiction. The breaking of the monogamy rule per se, however destructive

to a partner, is insufficient for the label. Many men masturbate to pornography, go to strip clubs and buy a lap dance, procure a prostitute's service, or have affairs during one or more phases of their coupled lives. Because partner disapproval of and distress about the man's sexual behavior is almost invariably present when a sexual secret is discovered, partner distress must be discounted as a sufficient criterion for the label. Men often initially feel differently about their participation in adult entertainment than do their wives. Because they have just profoundly upset their partner, they often are not forceful in asserting their private patriarchal view that real men partake in and are amused by such these entertainments beyond their wives' knowledge. It is problematic when a man with a classic lifelong paraphilia or with long-standing hypoactive sexual desire disorder of the Madonna-whore subtype are labeled *sexual addicts*. The erotic and sexual patterns of these men have been known for a century and already constitute a psychiatric diagnosis. Calling them *sexual addicts* often delays the recognition of the nature of their problem.

Scrutiny of Subdivisions 2, 3, and 5 suggests that most of these newly revealed sexual patterns had to do with a strong narcissistic sense of entitlement to preferred outside pleasures. It is relatively easy to perceive that each was doing something for the man. Sometimes it was a way of balancing the childhood origins of unresolved fear of psychological intimacy with the attraction to women's bodies. Sometimes it stemmed from middle-aged boredom with life. Sometimes it stemmed from a private refusal to tolerate the limits imposed by the incapacities of the partner. Regardless of these individual dynamics, the man has chosen to behave as though he is entitled because life is short, he is a man, his wife is disappointing, she is disappointed in him, etc. If the paraphilic men are added to these subdivisions, it can be seen that 75% of the sample are not best described as sexual addicts.

The remaining 25% of the sample—7 men—all have been on a downward spiral manifested by a dramatic desperate pursuit of sexual arousal. Gradually, the frequency of sexual stimulation intensified and the means of obtaining it broadened so that their pursuit dominated their lives. It crowded out social relationships, diminished concentration at work, led to the further emotional abandonment of their wives, and sometimes led to the commission of an egregious crime. The analogy to addiction was apt because substance abusers are well known to need their drug of choice so desperately that little else matters. These 7 desperate men were trying to solve well-established life problems that were more severe than those in Subdivisions 2 to 5. Their psychopathologies included—chronic suicidal depression, body dysphoric disorder, bipolar hypomania or depression, paralyzing social phobia, etc. These serious psychiatric disturbances were being camouflaged by the onset of this spiraling psychological deterioration. Bergner hypothesized that many of such men are seeking an escape from their sense of degradation (Bergner, 2002), a dynamic that does not fit 75% of the men in this sample.

It is apparent that the term sexual addiction is not apt in 75% of this series. Because 25% of this series could be categorized as paraphilic, there is a current need to better name 50% of these cases. Sexual addiction is useful for spouses who need to explain their partner's bad behaviors, however. In the immediacy of their despair, sexual addiction seems to be a diagnosis, an explanation, and a ticket to psychiatric care. The care that is provided should begin with an extended evaluation because the patient's circumstances, capacities, and grasp of the underlying personal and interpersonal issues vary considerably.

Clinicians can be helpful by reframing the situation: departures from the common public expectation for monogamy, long-standing stable sexual secret that demands a explanation other than addiction, decision to have a foray into the previously forbidden fantasized world—such as prostitution, strip clubs, pornography—that created seemingly irresistible pleasures, manifestation of a long-standing paraphilic problem that needs more clinical attention, underlying inadequately treated psychiatric illness, profound disagreement about appropriate male sexual entertainments. Each of these concepts in Subdivisions 2 through 5 provide the clinician with dynamic hypothesis to help them understand themselves better and end their problematic patterns.

Commingling these categories as sexual addiction runs two major risks: alienating the man who intuitively knows that he is not in essence similar to men who cannot stop drinking or who live for another infusion of heroin, prescribing treatment approaches on the basis of the category and not on his circumstance. When a therapist declares, "You are a sex addict and you need to be in a special institution or treatment program," the patient may decide that the clinician is not worthy of future visits. The clinician may regard the patient as being in denial and miss the possibilities that the diagnosis is so imprecise and pejorative that the doctor–patient relationship is sullied. As can be seen in this case series, lay persons are often not capable of making an discerning appraisal of their partners' offensive, frightening, and destructive sexual behaviors. However, the men themselves may intuitively understand what they are and what they are not.

None of the four comparative terms discussed in this article provide a suitable or apt label for the majority of cases. DSM-V should look askance at all of them and search both for a better term for sexual addiction and different ones for those who are not in a spiral of deterioration. In the meantime, those who are spiraling into deterioration should be recognized as, at times, being impulsive, compulsive, and addictive in their reliance on external impersonal forms of sexual stimulation. These are hallmarks of their desperation. Calling all men with shocking sexual secrets that undermine their wives' mental stability sexual addicts misleads the therapy approach to 75% of them and fails to fully appreciate the desperate tenuous state of the remaining 25%. Reid and Carpenter (2009) reached a similar conclusion

about terminology from their Minnesota Multiphasic Personality Inventory (MMPI-2) study. They described the heterogeneity of hypersexual subjects and concluded that there was a lack of evidence to support addiction, compulsivity, and obsession labels (Reid & Carpenter). After approximately 3 decades of clinical experience with treatments for sexual addiction, the field may be ready to reexamine the concept and no longer confuse its utility in getting people to treatment with the validity of the idea that the men have a discrete disorder.

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