

# ADDICTION OR COMPULSION: Politics or Illness?

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*Confusion exists about the use of the terms addiction and compulsion. In the case of sexual addiction and compulsion, the issues seem to be more volatile. In part this reflects our cultural ambivalence about sex, and in part this reflects professional ambivalence about sex addiction. This article summarizes the clinical usage of the terms sexual addiction and sexual compulsion and the issues that result across five separate disciplines: sexual medicine, addiction medicine, trauma medicine, psychiatry, and criminal justice rehabilitation. The summary reveals many parallels in the five disciplines and their reactions to the terms sexual addiction and sexual compulsion. Research across the disciplines points to a paradigm shift which may resolve issues of clinical understanding of the terms.*

Clinical words such as *addiction*, *compulsion*, *dependency*, and *obsession* are freely used and understood in popular literature and media. In many ways this represents progress, since it reflects a psychological mindedness in the public. It becomes confusing, however, when the terms are used in contradictory ways. It is even more problematic when social, political, and cultural agendas are mixed in with the usage of these words. In discussion of sexual addiction, volatile issues such as sex education, prostitution, pornography, abortion, AIDS, sex offending, and child abuse can obscure dispassionate understanding of the illness. The problem is critical because public policies on these issues are enacted.

Professional dissension over definitions further confuses the public. They ask what the difference is between addiction and compulsion. In the field of addiction, compulsion has been used as a definer of the addictive process since the early thirties. Yet some use the words interchangeably. In psychiatry, a clear difference exists between obsessive-compulsive disorder and obsessive-compulsive personality disorder which is often lost in the generic term compulsive, and either of these disorders can coexist with an addiction. This is further complicated by other fields, such as trauma, that routinely talk of "repetition compulsion" as part of "addiction to the trauma." The intriguing part of all this is that some forms of sexual addiction would fit all the above.

All professional groups have their public constituencies. Professionals dealing with sex have to confront the incredible social and biological importance of sex, the extreme cultural ambivalence people have about sex, and the resulting lack of sexual integration. To put it somewhat hyperbolically, we do not wish to deal with sex and yet are obsessed with it. The negative attitudes about sex that professionals still confront actually add to the obsession. Professionals have to pick their battles and their words. The result is that when addressing sexual addiction and compulsion, not only professional lenses but public lenses are needed.

The purpose of this paper is to provide an overview of what the terms sexual addiction and sexual compulsivity have meant within the context of five professional disciplines. They are sexual medicine, addiction medicine, trauma medicine, psychiatry, and criminal justice rehabilitation. The overview is not intended to be exhaustive, but rather illustrative of patterns and usages across these separate fields of study and clinical practice. It also points to an emerging paradigm, empirically based, which may bring us to a new level of practice and word usage in all the addiction fields.

## **SEXUAL MEDICINE**

The struggle has been for organizations such as the American Association of Sex Educators, Counselors and Therapists (ASSET) to establish sex as a legitimate scientific and clinical area for research. Early pioneers had to overcome extreme sexual prejudice, negativity, and moralism. Yet their persistence has made an extraordinary contribution to our knowledge of sexual functioning. Perhaps the landmark victory was removing homosexuality as a diagnosable illness from early versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. Ever since, professionals in this field have been on guard against anything that would make an illness out of any aspect of sex. The current backlash and conservatism of antigay legislation and the removal of sex education programs are seen as threatening these hard-won gains. Sex addiction is seen in this context as "pathologizing deviance" or medicalizing something that is not understood and is not an illness (Levine & Troiden, 1988).

The fears were fundamental. First, there was a fear of reversion to sexually negative stereotypes combined with a fear of unproven or unscientific approaches to sex, especially by outside professionals. In addition, there was distrust of self-help programs as potentially sex negative, a fear of the "abstinence" model of alcoholism applied to sexuality, and a fear of turning issues like trauma and addiction into excuses for nonaction, thus making clients into victims (McCarthy, 1993). Some sexology professionals remain unconvinced. Moser (1993, p. 222) writes: "Unfortunately, sexologists (and especially clinical sexologists) still await research that proves or disproves the existence of the new entity presumptively called 'sexual addiction.' . . . Attempts at creation of diagnostic criteria should consistently distinguish addictive and nonaddictive sexual behaviors, and do so in a societally neutral manner."

The clinical focus of sexual medicine and sexology has been to improve sexual functioning and empower people sexually. The unconditional acceptance of sexual desire was the starting point for sex therapy. Patients who were out of control sexually were at the periphery of clinical focus. The training and services offered were for people who wanted to be more sexual, not less. So when sex therapists encountered sex addiction, it required a major shift in clinical orientation. Sharon Nathan (1995), a sex therapist at the Ackerman Institute, describes how she had to "combat reflexes instilled by sex therapy training when treating a sex addict. . . . When confronted with a manifestation for which I had not yet learned a specific sexual addiction intervention, I had a tendency to revert to my sex therapy roots-to the detriment of the treatment." Like others, however, she concluded:

What appears undeniable is that there are people who are troubled by a sense that they cannot curb, control, or modify their sexual behavior, even when they are aware of the negative social, medical, and/or financial consequences that attend their inability to do so. It is the fact that such patients have been presenting themselves to us for treatment-rather than any scholarly debates in our journals-that has led us to consider the phenomenon seriously. While a small subset of these patients may be merely guilt-ridden about behavior that we deem perfectly normal, far too many seem truly out of control. Reassurances about their simply having a high sex drive ring hollow to therapist and patient alike. (p. 352)

Sex therapist Ginger Manley (1989) similarly reports her experience:

Having spent so much time and energy as a sexual health professional and having also been personally and professionally chastised by some of my colleagues for promoting awareness of sex addiction, I have reflected on the roots of this attempt to characterize sex addiction as non-existent and even as contrary to the appropriate work of sexologists. It strikes me that to

understand sex addiction, it is necessary to articulate the obvious on traditions that sex addiction poses to the belief system we as sexologists have adopted.

In response to these issues, Eli Coleman (1986) introduced sexology to the concept of sexual compulsion as an alternative to the concept of sexual addiction. His intriguing description of sexual compulsivity contained many of the conceptual and structural underpinnings of addiction. He pointed to the etiology of the illness as related to family dysfunction and child abuse. He noted the importance of factors such as shame, repressed sexuality, and a secret or "double life." He underlined the role of sexual acting-out as an "analgesic fix" that provides temporary relief but that creates, in his words, "a vicious cycle that simply feeds a greater need, "and results in more shame and dysfunction."

Fundamental to Coleman's position was the sexologist's concern for labeling the illness an "addiction" and the belief that "compulsion" was a less negative way to describe the problem. By 1988, in writing for chemical dependency professionals, Coleman described his dilemma as follows: "At this point, I prefer the term abusive behavior patterns or compulsivity because there seems to be more uncertainty and potential harm for the use of the term addiction. If I am to use the term addiction, I prefer to use terminology such as "like an addiction," or "addiction-like." By 1990 Coleman was describing sexual compulsivity as a variant of obsessive-compulsive disorder.

Coleman deserves credit for courageously withstanding criticism by sexology colleagues. He contributed significantly in three ways. First, he underlined the analgesic, relaxing quality of sex and its connection to anxiety—a very important beginning for the paradigm shift that is occurring. Second, he gave no quarter on anything that was sex negative or based on sexual stereotype or sexual prejudice. Finally, he did much to educate professionals in sexual medicine about the problem. Some, like Quadland (1985), supported Coleman. Others were sharply critical, yet Coleman stood his ground.

Compulsivity was perceived by some as an easier "sell" to the medical community—especially sexual medicine and psychiatric medicine. Compulsion was easier to accept by third-party payers. Addiction people regarded this position as essentially "selling out" for reimbursement purposes. They believed that it significantly understated the consequences and seriousness of the illness. To call the addiction a compulsion may have been politically expedient but did not reflect patient realities.

Sexual compulsion was seen as something that responded to psychotropic drugs and from which a patient could recover, and sexual addiction was seen as something from which a patient is always recovering. The contrast at one level involves some straw horses. The psychotropic drugs usually identified are selective serotonin reuptake inhibitors (SSRIs), some of which are identified with obsessive-compulsive disorder. Coleman, for example, cites that patients responding to these drugs is further evidence that the illness is obsessive-compulsive in nature. However, it is commonplace in contemporary addiction medicine to use SSRIs with alcoholism, drug addiction, compulsive gambling, eating disorders, and sexual addiction. These psychopharmacologic interventions are extraordinarily helpful in dealing with depression and lowering obsessive preoccupation (Sealey, 1995). Also, the issue of recovery versus recovering is far from resolved in the addiction community.

The point is, as Nathan and others point out, that therapists preferred the more "medical" term *compulsion* to *addiction*. Yet Nathan (1995) also notes:

Patients, however, seem intuitively drawn to "sexual addiction" and not, I think, just because it is a catchier phrase. Whether thinking of it literally or merely as a powerful metaphor, many patients see in the addiction concept ideas that speak to their own experience—the sense of being driven to do something even

though they know they will regret it, the feeling of being high when engaged in sexual acting out, the experience of painful withdrawal when trying to control sexual activity. (p. 352)

Like so many clinicians, sex therapists have found the stories of their patients compelling evidence for the existence of a problem. Embedded in the experiences of these patients are important themes, which are also recognized by the other disciplines we will review, whatever terms are used. For example, Joseph Glenmullen (1993) has written a sensitive, engaging, and clinically instructive book, *The Pornographer's Grief and Other Tales of Human Sexuality*. The keynote story is about a patient named Scott who was obsessed with pornography and the actual purchase of it. Notice how the words *compulsion* and *addiction* are used and the differing affective states involved:

Scott's compulsion to buy pornography was an addiction. The concept of sexual addiction is a relatively new one that is rapidly gaining credibility. Like other addictions, sexual ones begin with an irresistible urge. This is followed by a procurement ritual, an adrenaline-high state in which the individual follows an established set of steps to obtain a fix. The result is some form of climax, satiety, and calm. In the future, the cycle invariably begins again.

Glenmullen carefully documents the obsessive fixation, the pleasurable intense arousal, the repetitive behaviors, and the resulting satiation and release. Obsession, arousal, and satiation are key affective states that we will see identified across disciplines. He also includes compulsion as part of the addictive process. Perhaps most interesting of all, he underlines that Scott's presenting issue was inhibited sexual desire with his spouse.

Glenmullen, Nathan, Manley, and others have pointed to the significant role sexual deprivation plays in addictive acting-out. Addicts will be out of control in some parts of their sexual lives and in some others "compulsively" nonsexual. This condition is more than a problem of inhibition, lack of knowledge, or guilt. It represents an obsessive avoidance of things that some have likened to sexual "anorexia" because of parallels with the eating disorder. Compulsive overeating, anorexia, and bulimia have similarities with the continuum of sexual behaviors. That many sex addicts and/or their spouses present an intense antipathy toward their sexuality is of incredible significance clinically. Sex therapists have pointed out that many principles of sex therapy are strategically important to the recovery of sex addicts who have never really experienced healthy sexuality and might seek refuge in compulsive deprivation.

Sexual medicine has expanded its focus. Traditionally the field focused on sexual technique, sexual functioning, and attitudes. Now it includes each end of the continuum: those who have lost control as well as those mired in the super-control mode. One of the best examples is from Helen Singer Kaplan (1995), writing on the sexual desire disorders:

I am suggesting that hyperactive and hypoactive sexual desire disorders are the result of malfunctions or dysfunctions of the sex-regulating mechanism that ordinarily modulates our sexual desires and adjusts these to the opportunities and hazards of the environment. . . . According to this program, sexual desire disorders and eating disorders are analogous, in that both can be conceptualized as the resultants of important regulatory systems gone awry. More specifically, both hyperactive sexual desire and obesity/bulimia represent a pathological or dysfunctional lack of control over the respective function, whereas hypoactive sexual drive and anorexia nervosa are analogous in that both conditions represent a loss of an appetite as a result of pathological excessive over-control. (p.19)

Kaplain acknowledges the addictive sexual fix and highs of the addict, as well as the withdrawal issues, but adds that “anyone who has worked with these patients must be impressed with the compulsive quality of their sexual behavior.” Her preference remains, however, “to think of hypersexual behavior in terms of a deregulation of sexual motivation.”

### *ADDICTION MEDICINE*

David E. Smith, president-elect of the American Society of Addiction Medicine (ASAM), acknowledged the difficulties presented by sexual addiction to the mainstream of addiction medicine - and indeed medicine in general:

While we were on the verge of having the American Medical Association’s House of Delegates pass our historic motion declaring that addiction medicine was a recognized specialty... one of the questions they asked was, “Is sexual addiction part of the field of addiction medicine?” In part that was asked because the mainstream of medicine would have looked upon our specialty in a less favorable light had we included sexual addiction. Their concern was that we would label all of what they perceived as antisocial behaviors addiction, and put them in an addiction treatment context.

Then they asked, “Is cigarette addiction part of the field of addiction medicine?” and of course my response was, “Yes.” I said, “Sexual addiction is not part of addiction medicine, cigarette addiction is.” That’s one of the things that helped pass the motion because cigarette addiction is acceptable to the mainstream of medicine, sexual addiction is not. So part of the controversy is scientific and clinical, in part it’s political.

Establishing addiction medicine as a field of study and clinical practice was difficult in its own right. Like sexual medicine, it took decades of research, politics, and advocacy to develop a field responsive to client needs. Compulsive gambling, eating disorders, and other excessive behaviors were gaining acceptance as part of addictive disorders. Yet when it came to the critical turning point, leaders of the field had to exempt sex because they ran into when their excessive behaviors were gaining acceptance as part of addictive disorders. Yet when it came to the critical turning point, leaders of the field had to exempt sex because they ran into what their sexual medicine colleagues have known for a long time: aversion to things sexual run so deep in our culture that it is simply impossible to separate politics from science.

Many ironies exist in addiction medicine. One of the greatest is that the common use of the word “compulsive” by addictionists originates in early theoretical pioneers describing alcohol and drug dependence as a problem of eroticism. Sandor Rado (1969) described one of the criteria for drug addiction as “compulsive use” in the twenties and thirties. Under Freud’s influence, Rado saw addicts accessing pleasure centers in their brains which were ultimately sexual in nature. He would use phrases such as “metaeroticism” and “pharmacotoxic orgasm” to make the conceptual connection. Such constructs introduced the word compulsion into the intellectual heritage of addiction medicine, where it has been used ever since.

This use has continued into contemporary addiction medicine. For example, one of the classics in addiction literature, Leon Wurmser’s (1978) *The Hidden Dimension: Psychodynamics of Compulsive Drug Use*, appeared in the seventies. He made the case that addictions were fundamentally compulsive in nature and that they occurred on three levels:

- a: the compulsiveness of physical dependency based entirely on processes on the level of the cells; b: the compulsiveness of protracted withdrawal, a

gray area in theory; and c: the emotional compulsiveness leading first to start drug use and then to continue the search for the effect.

Wurmser was inclusive with this concept, seeing it in other behaviors, such as compulsive food use (which he clearly saw as an addiction) and compulsive hand washing (which he saw as analogous but, interesting from this article's perspective, not as an addiction).

Wurmser's perspective and usage are still current. In *Addiction Psychiatry*, Norman Miller (1995) writes: "Preoccupation, compulsive use and relapse constitute a behavioral strategy for identifying addictive behavior... Compulsivity is the continued use of a substance in spite of adverse consequences." (pp. 18-19) To be precise, most formulations of the addiction model include the concept of compulsion. Certainly, that tradition has been preserved within the realm of sexual addiction. In *Out of the Shadows, I* (1983) described an addiction cycle that had sexual compulsivity as a key component. More recent diagnostic criteria are similarly constructed. Jennifer Schneider (1994) proposed the following definition:

1. Compulsivity: Loss of the ability to choose freely whether to stop or continue a behavior.
2. Continuation of the behavior despite adverse consequences, such as loss of health, job, marriage, or freedom.
3. Obsession with the activity.

Aviel Goodman (1993) offers a parallel construct when he writes that addiction is "a disorder in which a behavior that can function both to produce pleasure and provide escape from internal discomfort is employed in a pattern characterized by 1) recurrent failure to control the behavior, and 2) continuation of the behavior despite significant harmful consequences." Goodman also emphasizes—rightly so, I think—that any definition must be about a "process" as opposed to a summary of diagnostic criteria. Even so, he still defines that process as including "compulsive dependence on external actions as a means of regulating one's internal states." Notice that Goodman emphasizes pleasure as well as affect regulation; Schneider also singles out the obsessional component. Both incorporate compulsivity as a foundation of their definitions.

The debate as to whether the problem is a sexual compulsion or a sexual addiction is quite confounding from an addiction medicine point of view, since, generically with addiction and specifically with sex addiction, one is used to define the other. Also, addictionists use the word *obsession*, which would naturally link the concept with obsessive-compulsive, yet the concepts clearly mean very different things. This practice is very confusing to professionals in sexual medicine and psychiatry. Further, many use the words *compulsion* and *addiction* interchangeably because they are so closely identified. This usage confuses everybody.

Finally, no consistent pattern of usage exists across the addictions. Compulsive gambling, compulsive overeating, and compulsive spending all are regarded as addictions, but we do not officially title alcoholism or drug dependency as "compulsive drinking" or "compulsive drug use." No comprehensive model or set of diagnostic standards exist to identify these syndromes or how they relate to one another. There are many texts designed to help assess multiple addictions (Donovan & Marlatt, 1988; L'Abate et al., 1992; Miller, 1980; Orford, 1985). Yet there is no attempt to untangle the language issues or to develop a common framework for identification. What the literature does show is that these conditions share common symptoms, common family history, comorbidity, and even common etiology. Just the debate about the combining of alcohol and drug treatment or the controversy about "chemical dependency" lays bare the resistance to a search for connections.

Parallel to what happened in sex therapy, addiction professionals had experiences with patients that pushed restrictive definitions. The need to combine alcohol and drug treatment

was because patients used both. Similarly, patients keep telling us about the connections between their sexual addiction and their chemical dependency or their gambling-or all the above. Note that our patients continue to teach us about their experience, which in turn forces us to abandon some of our most cherished concepts.

Edward Kaufman (1994) demonstrates the author's dilemma with these patient realities in his book *Psychotherapy of Addicted Persons*, in which he focuses on alcohol and drugs, although he says "these individuals also demonstrate addictive propensities to other risk-taking activities (e.g., gambling, motorcycling, skydiving) as well as to exercise, work, relationships, and sex." He adds:

I do not specifically discuss other compulsive behaviors... However, these behaviors have extremely high comorbidity with substance dependence and often complicate the picture, as many patients shift from drugs to equally destructive behaviors. These behaviors may also lead to a conditioned relapse, because they often have been powerfully associated with drugs and alcohol or can lead to stressors such as loss of jobs or relationships, which in turn leave individuals relapse prone. (p. 4)

Until addiction medicine untangles its terminology and integrates the diverse yet interactive realities of our patients, the problem of whether sexual compulsivity or sexual addiction is the more adequate designation will remain unresolved.

Yet there is extraordinary hope in the area of common etiology of the addictions to develop a clarifying framework for understanding the addictions and for being consistent with our words. There was a revolution in addiction medicine that occurred during the mid-seventies. The neurochemistry of the brain opened new vistas to understanding addictive processes. Researchers like Harvey Milkman and Stan Sunderwirth (1986) described three primary neuropathways for the addictions:

- The Arousal Neuropathway - High excitement, intense emotions such as fear, and extreme pleasure (such as found in gambling, high risk sex, stimulant drugs, dangerous behavior such as skydiving).
- The Satiation Neuropathway -Relaxing or soothing behavior; analgesic, self-medicating, or numbing behavior; anxiety reducing behavior (such as found in the use of alcohol, depressant drugs, eating, and repetitive actions).
- The Fantasy Neuropathway - Escaping into unreality or denial of reality (such as found in psychedelics or marijuana; mystical, religious, family or work preoccupation or obsession). (pp.30-31)

Milkman and Sunderwirth described sex as perhaps the most powerful addiction because it transcended each of these primary neuropathways. Sex is certainly about arousal, satiation, and fantasy. In all probability, every addiction to some degree taps into each of the neuropathways, forming a "cascade of neurochemicals" unique to each addict. By 1991, Milkman and Sunderwirth were in fact moving toward a "unified" theory of addictive neurochemistry.

Such an approach provides an empirical way to describe patient realities and be conceptually consistent. We have been like the proverbial blind men and the elephant, each having a significant part of the larger entity and giving impassioned voice to what is our truth. The arousal pathway surely accounts for the excitement and intense pleasure addicts report and for which clinicians have traditionally used the word "dependency." Similarly, satiation

would also describe the analgesic fix that Coleman terms "compulsive" (and in fact be consistent with usage in addiction medicine practice). Fantasy fits with the obsession and preoccupation that all observe as part of the process.

The parallels between addiction and sexual medicine appear to end when it comes to what Kaplan (1995) rightly describes as "hyposexual," or compulsive sexual aversion. Yet evidence also exists in addiction medicine for a deprivation mode. Bingepurge type cycles are legendary in alcoholism, sexual acting out, and gambling. They are especially obvious in the eating disorders. Hans Huebner's very useful book (1993) *Endorphins, Eating Disorders, and Other Addictive Behaviors* makes the case that "the self-starvation process in anorexia nervosa is identical to the behavior and psychology of drug addiction" (p. 16). There are many who document this position, but what marks Huebner's work is his careful description of the process of deprivation as an "endorphin mediated" experience.

The same themes emerge: arousal, satiation, fantasy, obsession, and deprivation. It is no wonder that our words and models would not be consistent. In fact, Shaffer and Milkman (1989) suggest that the addiction field is in a "pre-paradigm" stage of development:

These debates over legitimate methods, problems, and standards of solution serve to define competing schools of thought rather than to facilitate agreements among constituents of these parties. Such debates characterize and are hallmarks of a pre-paradigm period... Though the concept of paradigm was applied primarily to the physical sciences, it is applicable to the current state of affairs in the addictions. . . . In the absence of a paradigm, it is difficult to agree on what the important parameters of addictive disorders are. (p. xi)

And perhaps these words could characterize not only addiction medicine but its relationships with other fields as well.

### **TRAUMA MEDICINE**

It was only 30 years ago that prominent members of the medical community issued various statements that reports of childhood sexual abuse were greatly exaggerated and that the actual occurrence was very rare. Years later, with decades of extensive documentation, the debate continues under various forms, including the False Memory Syndrome movement. Similar patterns of resistance can be seen in the treatment of sexual assault or domestic violence. It is extremely difficult for clinicians to practice from either clinical detachment or scientific objectivity. Sexual politics, the media, conservative backlash, and the overall intensity make the fields of sexual medicine and addiction medicine look like calm waters by comparison.

Insert into this convoluted melee the growing understanding of trauma as a primary precipitant of addictive disorders. In the field of alcoholism and drug abuse, a growing body of literature underlines the relationship between child abuse and chemical abuse by both adolescents and adults. A similar finding is well established for the eating disorders. Sexual addiction was a natural area of research into childhood precursors of sexual behavior. In fact, while researching *Don't Call It Love* (Carnes, 1991), we found a high correlation between childhood sexual abuse and physical abuse and the number of addictions in adulthood (see Carnes, 1993).

From the addictionists' point of view, the treatment of trauma becomes incredibly important. In alcoholism, for example, there is growing concern that recidivism rates remain robust because when sober, alcoholics' memories return (Root, 1989). Rather than face that reality, they relapse. Some addicts switch from one addiction to another at this point rather than face

the painful realities from their past (Young, 1990). It is important that trauma treatment be incorporated in treatment planning for recovering addicts. This necessity comes to a field largely unknowledgeable about trauma and under siege to reduce the costs of treatment.

From the perspective of trauma treatment, the reciprocal is also true. Just as addiction therapists do not have skills in the assessment and treatment of trauma, trauma therapists are unfamiliar with addiction diagnosis and relapse prevention. In fact, treatment of the trauma before stabilization of recovery can precipitate relapse. Undiagnosed addiction in trauma treatment can at least stymie therapy and at most act out destructive scenarios to their ultimate and fatal conclusions. Evans and Sullivan (1995) describe this process well: "Simultaneously confronting the denial of their addiction and supporting their recovery from abuse requires that clinicians engage in a delicate balancing act" (p. vii). Put another way, the orientations of professionals in each field can be hazardous to problems presented by patients in the other. Yet the two disciplines have much to teach one another.

Add to this context the issue of compulsivity and addiction. Trauma specialists have long noted that trauma victims are vulnerable to addictive processes, that addiction can serve as a way to block traumatic memories, and that survivors also repeat traumatic events in an addictive fashion. Van der Kolk (1988), for example, writes about how trauma histories can be so supercharged neurochemically that survivors can be "addicted to the trauma." They repeat the trauma as a "repetition compulsion." This reenactment serves to reproduce the neurochemical experience or as an effort to resolve the original experience. Yet the language of addiction and compulsion is part of the scientific dialogue of traumatology.

Van der Kolk (1988) describes patterns that parallel the findings of Milkman and Sunderwirth and others:

This consistent pattern of hyperarousal alternating with numbing has been noticed following such a vast array of different traumas such as combat, rape, kidnapping, spouse abuse, natural disasters, accidents, concentration camp experiences, incest and child abuse. (P. 258)

Van der Kolk also describes how trauma victims will tend to swing to extremes and that early trauma actually results in an alteration of the biological strata of the brain that promotes extreme responses. Compulsive abstinence and deprivation are as familiar to clinical traumatologists as the compulsive excesses as a way for clients to cope.

A final parallel exists between the preoccupation/obsession that addictionists encounter and the dissociative disorders traumatologists find. The Jekyll and Hyde phenomenon so familiar in the addiction field is not very different from the compartmentalization found amongst trauma survivors. The capacity to "split" off from reality serves similar functions in both populations. Obsession is a way to dissociate whether it be for "acquisition" or numbing or precipitating high arousal or avoidance. What a compulsive overeater and an anorectic share is an obsession with food. When measures of dissociation such as the DES or SCID-D are used, high levels of dissociation are documented. Similarly, patient populations of sex addicts have been shown to be highly dissociative (Griffin-Shelly et al., 1995). The parallels raise the question about whether the same or overlapping processes are involved. Again we have the themes of arousal, satiation or numbing, fantasy, and deprivation.

Trauma specialists have also wrestled with what the words *addiction* and *compulsion* mean. Mic Hunter (1995), in an excellent essay, "Compulsive Sexual Behavior and Sexual Abuse," suggests that addiction "can be thought of as a collection of compulsive behaviors and obsessive thoughts."

In that sense, he describes compulsion as a subset of addiction that parallels much of mainstream addiction medicine. In response to the classical psychiatric definition of compulsion in the Diagnostic and Statistical *Manual of Mental Disorders*, he notes the problem presented by excluding pleasurable acts as part of the definition. He further elaborates:

Some people have argued that sexual behavior cannot be compulsive because it does not fit this definition; sexual behavior is pleasurable and is an end in itself. However, these people are likely comparing their experiences with sexual behavior and not the experiences of the sexually compulsive (e.g., the compulsive masturbator who reports that she "finally just gave in to the urge to masturbate. I really didn't enjoy it, but I couldn't focus on anything else until I got it out of the way." . . . Both compulsive and addictive behavior function as coping mechanisms—they either suppress or access memories and emotions. When assessing the addict's behavior, it is vital to keep in mind that each behavior, as well as the overall pattern of behavior, can serve either function. For example, an individual's compulsive masturbation may numb his or her loneliness and shame, whereas his or her compulsive affairs may be an attempt to access and experience joy and acceptance.

Note that the distinction between high arousal and numbing found in the trauma field echoes the findings in sexology and addictionology. Also, Hunter uses the word compulsion in a way that blurs what addiction means. When he writes about addiction, he means pleasure and numbing, whereas when he writes about numbing, he uses the word compulsion. Yet he defines them as equals. Hunter's usage reflects the confusion of all of us. His very perceptive chapter contains a reminder to his trauma colleagues: by the time addiction exists, "it has taken on a life of its own. The actions are so automatic that the addict will report that they 'just happen' as if he or she played no role in the action." Nor will patients connect their behavior with their traumatic history.

### **PSYCHIATRY**

Sexual addiction in the history of psychiatry probably starts with Freud's description in 1897 of "masturbation as the original addiction." He wrote that "masturbation is the one great habit that is a 'primary addiction,' and that the other addictions, for alcohol, morphine, tobacco, etc. only enter into life as a substitute and replacement for it" (p. 51). Freud did very little with this concept until his 1928 paper on gambling. Yet his description of addiction substitution would fit well within contemporary currents of addiction medicine. One hundred years later, we are just starting to comprehend the "switching" of addictions. One wonders what would have happened had Freud followed up on his original thinking.

The historical reality is sharply different. Classical psychiatry has a history studded with landmark misperceptions of addictive illness. These range from the legendary description of the Big Book of Alcoholics Anonymous as a book with "no scientific merit or interest," which appeared in a 1939 issue of the *Journal of the American Medical Association*, to the recent decades of prescription drug addiction enabled by psychiatric professionals. In part, the impetus for separate certification and training of addiction professionals has been the historical resistance within psychiatry to understanding addictive disorders. Dual disorder clients keep exacerbating the uneasy boundaries between the two professions. Who has dominion over the patient is a question that has been a source of tension in many physician lounges over the years. All of this occurs in a time when existing resources are rapidly diminishing for both psychiatry and addiction medicine. Insert now the use of the terms sexual compulsion and sexual addiction.

Obsessive-compulsive disorder is clearly the province of psychiatry. Yet within the DSM-IV (APA, 1994), the reader is urged to remember that some activities, such as eating (e.g., Eating Disorders), sexual behaviors (e.g., Paraphilias), gambling (e.g., Pathological Gambling), or

substance abuse (e.g., Alcohol Dependence or Abuse), when engaged in excessively, have been referred to as "compulsive." However, these activities are not considered to be compulsions as defined in this manual because the person usually derives pleasure from the activity and may wish to resist it only because of its deleterious consequences. (p. 422)

The caution is given so as not to confuse the OCD patient, who knows his obsession is not real, is disturbed by it, and does it anyway, with the sexually compulsive patient, who is deluded by his obsession, is minimizing risk, and is caught up in the pleasure of it. Within these guidelines, sexual compulsion and obsessive-compulsive disorder are separate disorders which can coexist.

Yet nowhere in the DSM-IV other than this reference is sexual compulsivity identified. Nor is sexual addiction identified. Sexual addiction was identified in two places in the DSM-111-R, but both references were removed in the later version. Clearly, both concepts have not been integrated into the mainstream of psychiatric diagnosis. In fact, as Schneider and Irons (1996) point out, "addiction professionals who encounter both compulsive and impulsive sexual acting-out behaviors in their patients have experienced paradigm and nomenclature communication difficulties with mental health professionals and managed care organizations who utilize DSM terminology and diagnostic criteria." Further, the authors compare the language and criteria for substance abuse (considered an addiction) and pathological gambling (considered an impulse disorder) and note few differences. They then provide a helpful guide to using existing DSM language and criteria with sexually addicted patients. As for meeting the criteria for obsessive-compulsive disorder, they write: "When sexual or seductive (romantic) behavior is the focus of obsessive mental activity, is neither acted upon nor produces gratification, and is causing significant distress, then it may meet the criteria for OCD. In our experience, such rare cases are associated with non-sexual behavioral manifestations of OCD."

Some call for a significant revision and expansion of the OCD criteria. Wong and Hollander (1996) suggest the term Obsessive Compulsive Spectrum Disorders (OCSDs). Within the "spectrum" are two subclusters: disorders of impulsivity and neurologic disorders. What both clusters have in common is loss of control, repetitive behavior, and obsession. An example of the neurologic disorder would be autism. In the "impulsive" category they include compulsive buying, pathological gambling, body dysmorphic disorder (BDD), and sexual compulsivity. On occasion, they use sexual addiction as a term to describe sexually compulsive behavior. A careful reading of this article reveals that they share the same fate as the rest of us who write on these matters of using the same words (addiction, compulsivity, impulsivity) with different meanings interchangeably to describe the same phenomenon.

In fact, what is striking about Hollander and Wong's work, which is a substantial contribution filled with much insight, is that the end result is very similar to what has been observed in the other fields described above:

- the recognition that a number of affect-regulation mechanisms are involved, including arousal or gratification, anxiety reduction, obsession, and deprivation
- the comorbidity with other parallel issues, such as substance abuse and eating disorders
- the common occurrence of depression, attention deficit disorder, and dissociative trance-like states
- the problem of the same criteria (i.e., loss of control, repetitive behavior, obsession, life impact) appearing in a number of DSM-IV categories

Yet Hollander and Wong remain understandably psychiatrically oriented. They are especially interested in comorbidity with OCD, in responsiveness to SSRIs, and in the role of the serotonin system. They do not mention key elements in the addiction literature that would support their

case. For example, the literature on compulsive spending continues to grow more robust, and the distinction often made between compulsive spending and compulsive debting would have demonstrated the issues of pleasurable and nonpleasurable compulsivity in the same arena.

Further, they make a similar observation to the one Irons and Schneider (1996) noted above:

True sexual obsessions can be seen as a form of OCD, with intrusive, repetitive, and vivid sexual images that are morally repugnant to the individual and, hence, anxiety-provoking. These may include intrusive visual images involving sex with animals and children, for example, that are ego-dystonic. The thoughts about sexual material do not usually prompt sexual behavior. . . . Sexual impulses, on the other hand, fall more into the realm of impulsive-type conditions, are repetitive, and pleasure-producing. Such conditions include compulsive masturbation and repetitive promiscuous sexual behavior, which can also be seen as a form of addiction. (Hollander & Wong, 1995)

Reflecting on Hollander and Wong's conceptual framework, one wonders if the formulations for compulsivity and the formulations for addiction are but mirror images of the other. The mirror reverses the order of things. With addiction the emphasis falls on the pleurability, and with compulsion the emphasis falls on the nonpleasurable. Yet each acknowledges the value of the other.

Two key principles, however, should sharpen the images for everyone. First, diagnosing from a specific sexual behavior alone is a mistake. Consider the case of Art, a 32-year-old graphic arts designer who, in his ninth month of sexual addiction recovery, had a relapse. One of the most troublesome parts of his addictive pattern was unsafe, anonymous sex with other men in public bathrooms. He described his experience when cruising bathrooms in general as exhilarating. His heart would race, he was extremely aroused sexually, all his senses were heightened, and he felt "invulnerable," even though he had been arrested twice. He described his relapse differently. He was bored, not aroused, and simply wanted "to get it over with" so he could go to sleep. This scenario was not unique in his history but definitely a subtheme to the overall pattern of high arousal.

Note that it was the same behavior used in different ways to regulate affect. In his general pattern, it was clearly the mind-splitting "rush" of arousal that addiction professionals so quickly identify. His relapse fit more the criteria of non-pleasure of obsessive-compulsion. Yet it still was the same behavior. The organization of the paraphilias and non-paraphilias in the DSM-IV, in this context, is virtually meaningless because it is more important to know what the behavior is doing for the client. What makes this situation more complex is that most patients string a number of behaviors from a number of categories together and use them as drug addicts would use uppers and downers. In addition, they mix in other ways to alter their mood, including food, gambling, alcohol, high-risk experiences, and so forth. Could it be that out of these terribly complex patterns, we clinicians applied labels which we were familiar with and which were accurate as far as they went-and ignored the rest, since they did not fit our categories?

The second clarifying principle is even more important: wherever you have excess, you have deprivation. Two clinicians who described this well are Merl Fossum and Marilyn Mason (1986) in *Facing Shame*, which is probably the best book on family therapy to come out of the eighties. They describe a shame cycle embedded in superhuman standards. When a dieter fails to live up to the inordinantly high requirements of the diet, the dieter will binge. Taken to its pathological extreme, the binge-purge dimensions emerge, which are so familiar in eating disorders but in other addictive disorders as well. The authors also echo the living in the extremes described in the other fields above. Fossum and Mason, however, underline the common issue of shame or of feeling defective at being able to regulate one's behavior. They also point out that compulsive hoarding, compulsive cleaning, anorexia, and other deprivation responses are used to balance excess.

Consider the case of Ann, who, when she was out of control sexually, was anorectic with food. Then she would shut down sexually, become compulsively nonsexual, and then compulsively overeat. Over the years, she would gain and lose a hundred pounds, which served as an absolute index to where she was sexually. If you simply focused on the sexual problems, you would miss the significance of the larger pattern in Ann's life. More importantly, this is not about comorbidity. These issues are interactive in nature. The neurochemical cascade patients like Ann create for themselves goes far beyond our traditional concepts of compulsion and addiction and far beyond our traditional professional boundaries.

Nowhere does this become more apparent than when the patient is a sex offender.

### **CRIMINAL JUSTICE SYSTEM**

"Sex offenders do everything in their power to avoid responsibility. That is why I believe the addiction concept is so harmful when we are discussing issues of sexual deviancy. It just provides more reasons for the offender to excuse his behavior." This statement by Steven Jensen (1989) starts an article debating the merits of the sex addiction model in *Contemporary Sexuality*. There are many things about sexual addiction that disturb sexologists, but one of the most often voiced is that sexual addiction as a concept absolves offenders from responsibility.

Surprisingly similar sentiments come out of the addiction community. Peter Pociulyko (1994) writes in an editorial:

This habit of loosely labeling individuals as dysfunctional leads to pathologizing every behavior, treating behaviors as symptoms and attributing them to an external source of past trauma. This attitude has helped create in some a core identity of "I'm the addict," which gains them sympathy, and a belief that "I'm not responsible," which provides an excuse for any failure.

Pociulyko rightly makes the distinction that this is not true within the mainstream addiction tradition, whose foundation is built on accountability. Yet, interestingly, this changes for him if it involves sexual issues.

To further underline the polarities of opinion about sex addiction and sex offending and how so many strong reactions cross professional lines, note the very strong case made for sex offending as sexual addiction by Judith Herman (1988), one of the leading pioneers in the trauma field. Noting how traditional offender treatment approaches are based on models inconsistent with feminist social theory, she writes, "The concept of addiction offers a point of intersection for the observations developed by psychologists and those of social theorists. A model of addiction also offers clear guidelines for the development of offender treatment programs, for preventive educational work and for the legal and regulatory strategies." In addition to noting the conceptual consistency with a feminist critique of the culture, she also reviews the literature and observes what we have noted in other disciplines, that a range of responses exist, including abstinence, binge/purge responses, and escalating addictive patterns.

Herman astutely observes that not all offenders are addicts and only a small subset of addicts are offenders. Later studies confirm her insight. GERAL BLANCHARD'S (1991) study of the Wyoming prison population found that 55% of 109 offenders fit the diagnostic criteria for sex addiction. A similar study by IRONS and SCHNEIDER (1996) of 129 physicians also found 55% fit the criteria for addictive sexual disorders. This becomes important since treatment outcomes improve with differential diagnosis. GRAHAM (1994), for example, reports a 3% recidivism rate in a five-year follow-up of sexually addicted sex offenders. Most important, Herman points to the addiction model as starting treatment with accepting consequences for behavior.

Yet Herman (1988), who writes with great conceptual clarity, also blurs the meaning of compulsion and addiction, reflecting the usage in mainstream addiction medicine. At one point she writes, "Most sex offenders who do get arrested have already developed a well-established compulsive pattern. Because they are rarely detected until they have reached an advanced stage of addiction, we know very little about the early and middle stages in the

development of the pattern of sexual assault" (p. 713). A reader could interpret the statement as considering a well-established compulsive pattern the same as an advanced stage of addiction. Or it could be a subset.

Herman is not alone. The work of Mark Schwartz with sex offenders has vastly added to our knowledge about the role of abuse in offending behavior. His writings document the high arousal, the tension reduction, the extreme dissociation, and the anhedonia. Schwartz works very hard to parse out the component parts of the offending process, yet notice his language as he defines treatment in a recent article: "Because the factors that etiologically contribute to hypersexual behavior cause compulsivity symptoms, while addictive cycles maintain and perpetuate the behavior, effective treatment requires an integration of psychodynamic and trauma-based approaches to addictive behavior with cognitive behavior models" (Schwartz & Masters, 1994). As an integration of different approaches, the article is masterful. As to the relationship of compulsion and addiction, it is unclear.

Like other fields, sex offender treatment brings up intense emotional responses for professionals and the public. Similarly, the same topic areas occur: sex, addiction, trauma, and compulsion. Also, the themes of high arousal, satiation, obsession, and deprivation emerge as critical factors. What are the implications for our language and clinical practice?

### **CONCLUSION**

By reviewing the literature across disciplines, a number of conclusions emerge:

- Each field was initiated in the midst of controversy and is under extraordinary pressure now, so matters of turf, territory, credentials, and control are accentuated.
- The words *addiction* and *compulsion* have a rich and convoluted history, providing a variety of meanings for the same words.
- Across these fields common themes emerge: intense arousal, including pleasure; satiation, including anxiety reduction; fantasy, including preoccupation; obsession; dissociation; and deprivation, including aversion as well as binge-purge cycles.
- Sexual behaviors can be used to tap into any or all of those neurochemical processes, forming unique cascades of internal chemistry, which our words have been inadequate to describe.
- Sexual excess or deprivation is found to exist and interact with other excessive or deprivational forms of behavior, including eating, gambling, and substance abuse.
- The current DSM-IV classification system focuses on sexual behavior and not the affective use of the behavior, nor does it provide a common framework for documenting the interactions among excessive or deprivational behaviors.
- The words *addiction* and *compulsion* as they are currently used and defined are probably inadequate for the new paradigm required to make the necessary classification changes.
- There is in the common themes found across all the disciplines reviewed a foundational, empirical basis for such a paradigm.
- To achieve such a change will require a level of generosity and collaboration that has not typified professional interaction across these fields thus far.

This last conclusion is of greatest concern. Many years ago, family therapy was stirring up lots of controversy because the systemic approach crossed so many disciplines. Minuchin and colleagues observed in 1978:

Therapists now seem to be working with mixed theories. As a result, systems thinkers, using old terms to explain new concepts, sometimes arrive only at global formulations. Psychodynamic clinicians, expanding their language to incorporate new meanings, may try to save old paradigms by creating complex elaborations, which serve only to confuse. (p. 76)

At another point they comment:

Therapists, like other human beings, are a product of their society. They are members of a guild who are trained by the same method, read the same books, and transmit similar ideas. . . . In the field of helping people, beliefs speak with a clearer, sharper voice than results. (p. 324)

We hope that, like our family therapist colleagues two decades ago, we can create the forums to crystallize a new paradigm that will be effective for our patients and that will help us expand our understanding rather than confuse and divide us.

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