The Case for Sexual Anorexia: An Interim Report on 144 Patients with Sexual Disorders

Patrick J. Carnes, Ph.D.

The term "sexual anorexia" has been used to describe sexual aversion disorder (DSM code 302.79), a state in which the patient has a profound disgust and horror at anything sexual in themselves and others. This paper reports on a project to document and expand criteria for sexual anorexia and to discern co-morbidity with sexual addiction. At this point one-hundred and forty-four patients have participated in an extensive assessment of sexual disorders upon admission to a treatment facility. Early data suggests important implications for further research and diagnostic criteria.

For some time the term "sexual anorexia" has been used to describe patients who have an extreme aversion to anything sexual (Hardman and Gardner, 1986). This condition goes far beyond inhibition or sexual negative attitudes. It is an obsessive state in which the thought of being sexual by oneself or with others is almost unbearable. The anxiety produced is chronic and impacts ones ability to do even some of the most basic social functions. Suicidality and isolation are frequent concurrent issues. In the *Diagnostic and Statistical Manual – IV* (1994) Sexual Aversion Disorder (302.79) is described as follows:

A. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital contact with a sexual partner.
B. The disturbance causes marked distress or interpersonal difficulty.
C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction).

That sexual anorexia has been used to describe this condition is in part because the term is more comprehensible to patients and it separates the problem from milder sexual disorders for professionals (Carnes, 1997). The etymology of the word anorexia reveals that the term means "interruption of the appetites." Many observers have noted the coincidence of sexual anorexia with other forms of compulsive deprivation including food anorexia, compulsive debting and hoarding, compulsive athleticism and various forms of traumatic abstinence (Fossum and Mason, 1986; Heubner, 1993; Yates, 1991; Yellowlees, 1985). The term actually "fits" better with other concurrent conditions involving deprivations. Some actually have argued how this collection of "deprivations" – or general anorexic state – seem to occur most often in religious, traumatic, or cult circumstances (Bell, 1985; Bloom, 1996; Briere, 1992). Finally, the term sexual anorexia has been widely used in twelve-step programs which have groups specific to the condition that have been helpful (Sex and Love Addicts Anonymous, 1992). While the term sexual anorexia has been useful in describing aversion desire disorder, literature defining criteria for the condition has been limited. Many characteristics are commonly observed but no uniform effort of defining it from a sexual anorexia framework exists thus far.

Another problem emerges in determining the relationship between sexual anorexia and sexual addiction. Sex addiction specialists have long noted that sex addicts could also be sexually aversive (Butts, 1992; Carnes, 1991; McCarthy, 1994). And earlier study, for example, documents that seventy-two per-cent of sex addicts would describe their behavior

as more of a binge purge phenomenon (Carnes, 1997). In that sense, the sexual disorders have characteristics that parallel the eating disorders with compulsive overeating, bulimia, and anorexia. Many researchers and clinicians have noticed those parallels. Some have even proposed a separate category of addictions entitled the appetite addictions (versus the "process" addictions or the "chemical" addictions). While sexology has been very thorough in documenting the general nature of sexual disorders, there has been a reluctance to acknowledge these extreme conditions. Recently a common consensus is emerging that both extremes exist but some still debate terminology preferring terms like hypersexuality and hyposexuality (Singer, 1995). Both the trauma field and the addiction field have been influential in further delineating the existence of these extremes (Carnes, 1996).

A growing clinical perspective exists, which sees patients mixing and matching deprivation and addiction behaviors in fixed compulsive patterns. They become like modules that can be switched back and forth. For example, consider the patient who comes from extremely abusive circumstances with a mother who is a compulsive gambler, sexually compulsive, and worded as a prostitute. This woman as an adolescent and young adult was a food anorexic and a sex addict. When she married she became a compulsive overeater and gained almost one hundred pounds. She also was sexually anorexic with not just the absence of desire but great fear and disgust for sexual conduct with her husband. When she divorced she immediately lost all the weight gained and returned to indiscriminate, high-risk sexual behavior. She remarried three more times with the same pattern repeating itself in each marriage. Thus aversion and addiction would switch depending upon her marital status. There was a hundred pounds that was an absolute index to where she was sexually over a period of twenty-eight years.

To understand this phenomenon clinicians must reflect on: 1) the larger picture in which these patterns weave in and out of various disorders; 2) the commonalities specific within the extremes of sexual disorders and their influence on one another; and 3) the specific nature of sexual aversion so that it can be documented further and treated more successfully. The purpose of this paper is to report on a project to clarify diagnostic criteria for sexual anorexia and discuss the larger implications for addiction research.

Criteria For Sexual Anorexia

The clinician must first understand that sexual anorexia does not simply involve an absence of arousal or desire. Rather typically the core is an obsessive hatred and fear of sex. Essentially criteria must evolve out of the parameters of the obsession itself as the patient experiences it. Self-help organizations such as Sex and Love Addicts Anonymous (1992) have been describing this problem in their literature for some time. To start this project we did an extensive literature review (Carnes, 1997), developed criteria, and asked patients if these criteria fit for them. We revised the format twice and then incorporated it into a general sexual assessment form, which also included criteria for sex addiction. The problem was to distill anorexia criteria consistent with what patients said the problem was while reflecting professional findings as well. The criteria were presented to conferences of professional and to gatherings of recovering persons. What follows are the current working criteria that evolved our of this process:

1. **Recurrent pattern of resistance or aversion to any sexual activity, initiative, or behavior.** The pattern extends beyond behavior to include any activity related to sex or any efforts to initiate sex. A core antipathy to all things sexual exists.
2. **Persistent aversion to sexual contact even though it is self-destructive or harmful to relationships.** Anorexics report many losses because sex was difficult or unbearable

including broken relationships and rejecting behaviors that others were not able to understand.

3. **Extreme efforts to avoid sexual contact or attention including self-mutilation, distortions of body appearance or apparel, and aversive behavior.** This criteria represents the most extreme of anorexic behavior. The self-mutilation and self-cutting which is sex negative is especially common in abuse survivors. It can extend to deliberate efforts to make oneself unattractive not just cover up sexually. Sometimes sexually unattractive behavior will also occur.
4. **Rigid, judgmental attitudes towards personal sexuality and sexuality of others.** Anorexics are extremely critical of anyone doing anything sexual. They can sometimes come off as the "sex police" because of their intolerance of others attitudes, behaviors, dress or activities. If they are sexual themselves, they have great self-criticism over what they have done.
5. **Extreme shame and self-loathing about sexual experiences, body perceptions, and sexual attributes.** Anorexics are often attractive people who experience extreme discomfort if this is noticed or acknowledged by anyone. Compliments become threatening. Sexual parts of the body are sources of deep shame.
6. **Sexual aversion affects work, hobbies, friends, family and primary relationship.** The consequences of sexual anorexia are legion. Patients report making significant and destructive work decisions because the potential for some sexual possibility existed. Hobbies were modified or abandoned. Friends were restricted or rejected. Family dynamics became dysfunctional because of tension around sexual issues. Primary relationships perhaps suffered the most restrictive reactivity.
7. **Preoccupation and obsession with avoiding contact and with sexual intentions of others.** Anorexics obsess about potential sexual contact to the extent that significant time and sleep are lost because of the obsession. Most often this obsession is about suspected sexual intent or desire of others. Anorexics will scan constantly for the potential sexual approach to self or others. Either is considered threatening.
8. **Despair about sexual functioning.** Acute depression and suicidality were frequently found in anorexic populations. In a society that equates well-being with sexual activity, the patient feels fundamentally flawed and defective.
9. **Avoiding intimacy and relationships out of fear of sexual conduct.** Fear of sex affects all social contact. Anorexics tend to isolate and initiate few friendships. In part that is because of the shame and feelings of defectiveness, but also social relationships create potential for sexual approaches.
10. **Distress, anxiety, restlessness, or irritability because of sexual contact or potential contact.** Patients often are extremely agitated over discussing these issues even though it is at their request and initiative. Fear and anger quickly emerge as even the most obvious examples of the problem are discussed. What often motivates them to persist in therapy is the extreme pain they have been in and the realization something can be done to help them.

Method

These criteria were incorporated into a sexual disorders assessment form to be used for all patients who are evaluated with sexual problems. Nursing and medical staff were all trained in the use of the form as part of the routine sexual evaluation process which included an extensive sexual history and psychiatric evaluation. Those admitted for sexual disorders to our treatment facility were given this assessment usually within forty-eight hours of admission.

Since the facility specializes in addictive disorders, trauma treatment and general psychological conditions some assessments were conducted after the sexual disorder was identified as part of treatment for other conditions. When a sexual disorder was identified, this extensive assessment was conducted by a nurse and a psychiatrist. For data to count, the patient, the nurse, and the psychiatrist all agreed that the criteria fit the patient's circumstances.

The study was initiated in early 1997. This paper reflects patient activity through May of 1998. During this period 687 patients were admitted to the facility. Of those, two hundred and seventy-one were identified by staff as having possible sexual disorders and sent for an assessment. Sixty-three (44%) were assessed by the staff as sexually aversive by DSM criteria. One hundred and twenty-two (85%) were determined to be sex addicts. Twenty-one (15%) were assessed as having both conditions. The total number of extreme sexual disorders (hyposexual or hypersexual) was one hundred and forty-four. See figure one for a graphical summary of the patient population.

Figure 1

Forty-one per cent of the sexually anorexic patients were males and fifty-nine per cent were females. All were Caucasian and ranged in age between nineteen and fifty-eight. Fifty-six per cent met diagnostic criteria for acute depression. The following data create a profile of the sixty-one patients:

- 67% reported a history of sexual abuse
- 41% reported a history of physical abuse
- 86% reported a history of emotional abuse
- 65% reported members of the immediate family as some type of addict
- 40% reported having a sex addict in the immediate family
- 60% described their family as "rigid"
- 67% described their family as "disengaged"

Over two thirds of the anorexic population indicated having other compulsive or addictive problems including the following:

- Alcoholism (33%)
- Substance Abuse (25%)
- Compulsive Eating (25%)
- Caffeine Abuse (26%)
- Nicotine Addiction (23%)
- Spending/Debting (22%)
- Bulimia or Anorexia with Food (19%)

It is important to note how early in treatment this data was gathered. These patients may in fact have altered their opinions as they progressed in treatment. For example, it is the author's experience that reports of abuse history expand dramatically as a patient's understanding increases. Similarly, their perceptions of compulsive and addictive behavior may expand as treatment progresses. Yet if the criteria are to be useful, the patient must be able to identify with them early in therapy. Thus we felt it important to see of the criteria would serve to screen patients early in therapy. Three brief cases follow to further illustrate the profile of the sexual anorexic patient.

William

William was in his early forties and had never dated or been sexual with a woman. He was admitted after a suicide attempt. William's mother was an alcoholic who died from her alcoholism. She also was very promiscuous having continuous affairs. William's father was successful in his professional life but despaired over the affairs of his wife. Unable to cope with further betrayal, he suicided when William was twelve. His mother was extremely flirtatious with William's friends. In fact some of his most agonizing memories were of her flirting at the country club pool. In addition she propositioned her son. She explained that one of her fiends had sex with her son and how wonderful that was. He would have to fend off intrusive physical approaches by his mother. After her death in his early twenties, William became a recluse. He never dated because to do so somehow would be a betrayal of his father. He reported that no woman was trustworthy. Nor did he have any sexual desire. Thoughts of sexual contact were repugnant. All his social life dwindled. He lived off his trust and did not work. Finally his loneliness became unbearable leading to his admission for treatment.

Nancy

Nancy was admitted when a relationship failed. She was a thirty-eight year old virgin and never had been sexual with anyone. She was a very attractive and vibrant person but could not allow herself anything close to sexual contact. She finally fell in love and had sexual feelings for a gay man friend of hers. She was crushed when he told her he was not interested in a sexual relationship. Her therapist helped her to realize the significance of the fact that the only relationship she ever allowed herself was at the outset bound to fail – and that she knew that from the start. As a child she lived with alcoholic parents who had savage, violent fights. While they did not batter their children, they were so absorbed in their own drama, the kids suffered profound neglect. Nancy developed a relationship with the couple who lived next door who were attentive to her. They often fed her, took her shopping, and spent time with her. The price for this was Nancy being willing to spend time in the nude with them with mutual masturbation. Pictures were taken. Even watching TV was without clothes. Nancy never told anybody for fear her refuge would be taken away. Nancy believed at her core that for her to have her needs met, she would have to be sexual. She simply refused relying instead on extreme self-sufficiency. At the age of fourteen she made a pact with herself: no sex. Not now. Not ever. She held that pact until the friendship with the gay man and a chink appeared in her armor.

Rosalie

Rosalie's first marriage was traumatic. Her husband was a vicious man who was often sexually violent. One of his favorite punishments for her was playing Russian roulette pointing the barrel of his pistol up her vagina. Like many victims of violence she was sure she could not escape her abusive husband. The nightmare of that marriage lasted eight years. She then met a very kind high school teacher whom she promptly married. When she remarried, she found it psychologically and physically painful to have sex. She became very depressed over her inability to connect with her new husband sexually. He was after all a very different kind of man. Upon admission she manifested many post-traumatic stress disorder symptoms.

Her childhood history revealed that her mother had died when she was in the second grade and she had been raised by her father. When he remarried, his new wife had a

daughter from a previous marriage. Later Rosalie learned that he sexually abused this stepdaughter throughout her elementary and junior high years. At first Rosalie could not believe it because he always encouraged her to dress modestly. Despite being his "special" child Rosalie was sent to live with her grandmother. Knowing what happened to her stepsister, Rosalie now interpreted that her father did not want her to know what he was doing. She still wondered why her father put her on a pedestal and abused the other girl so badly. Rosalie also struggled with her current husband who compulsively masturbated two to three times a day. He argued that since their sex life was non-existent, he was driven to masturbation (except it was a lifelong problem). All she knew was that every time she discovered him masturbating she felt incredible rage.

Results

All of these patients were assessed early in their treatment process, and many of them as they came out of "crisis" situations. With progress in therapy, the de-escalation of their life circumstances, and the disintegration of denial, these patients with time in fact might have identified with additional criteria. In a parallel study of sex addiction criteria patients' initial assessments were somewhat lower than recovering addicts who had an average of two and a half years of recovery (Carnes, 1998a; Wines, 1997). A similar pattern might exist for this population. Even so, eighty-nine per cent identified with at least three of the criteria. The following list of criteria presents the corresponding percentages of patients who met the criteria.

Criteria	**%**
1. Recurrent pattern of resistance or aversion to any sexual activity, initiative or behavior.	87%
2. Persistent aversion to sexual contact even though it is self-destructive Or harmful to relationships.	51%
3. Extreme efforts to avoid sexual contact or attention including self-mutilation, distortions of body appearance or apparel, and aversive behavior.	29%
4. Rigid, judgmental attitudes towards personal sexuality and Sexuality of others.	48%
5. Extreme shame and self-loathing about sexual experiences, body perceptions, and sexual attributes.	73%
6. Sexual aversion affects work, hobbies, friends, family and primary relationship.	52%
7. Preoccupation and obsession with avoiding sexual contact and with sexual intentions of others.	44%
8. Despair about sexual functioning.	70%
9. Avoiding intimacy and relationships out of fear of sexual contact.	60%
10. Distress, anxiety, restlessness, or irritability because of sexual contact or potential contact.	60%

In the case histories as well as in the profile data certain characteristics of sexual anorexics stand out. They tend to come from families in which other members of the family have addictions. In a high percentage of the cases those family members are sex addicts. Also

sexual anorexics report addictive and compulsive behaviors for themselves. They tend to have depression and post-traumatic stress disorder symptoms. Their family systems are usually rigid or disengaged or both. They usually have suffered serious abuse in their history, a significant portion of which is sexual. Almost all feel hopeless about their feelings of sexual aversion.

This profile parallels the characteristics of sexually addicted patients. Sex addicts come from rigidly disengaged families in which other family members are addicts (Earle, 1989; Carnes, 1991). They also report substantial histories of abuse including sexual (Schwartz, 1996; Carnes and Delmonico, 1996; Miller, 1996; Tedesco, 1997), and they manifest other addictive and compulsive behaviors. Finally, there is profound despair at not being able to stop their behavior. In our patient sample, one hundred and twenty-two patients fit criteria for sexual addiction. Some comparison statistics are:

Profile Dimension	**Anorexics (%)**	**Addicts (%)**
Meet criteria for depression	56	52
History of sexual abuse	67	50
History of physical abuse	41	43
History of emotional abuse	86	77
Other addictions/compulsions	67	71
Other addicts in family	65	59
Rigid family	60	60
Disengaged family	67	59

This data for sex addicts comes from the same sexual assessment completed early in treatment. The earlier caveat applies in that the data may reflect both denial and lack of knowledge and would alter substantially as treatment progresses. Those familiar with research on sex addicts will note that the percentages are lower than research done on sex addicts who have been in recovery for some time (Carnes, 1998a). Even so, the profiles of sex addicts and sexual anorexics have meaningful parallels.

A growing body of literature exists on diagnostic criteria for sex addiction (Schneider, 1994; Irons and Schneider, 1996; Wines, 1997; Goodman, 1998; Carnes, 1998a). The following lists the criteria used for sex addiction diagnosis in the sexual assessments described in this preliminary study. The percentages of criteria that patients identified as accurate about them are also listed.

1. Recurrent failure (pattern) to resist impulses to engage in specific sexual behaviors. 73%
2. Frequent engaging in those behaviors to a greater extent or over a longer period of time than intended. 66%
3. Persistent desire or unsuccessful efforts to stop, reduce, or control those behaviors. 67%
4. Inordinate time spent in obtaining sex, being sexual, or recovering from sexual experiences. 58%
5. Preoccupation with the behavior or preparatory activities. 37%
6. Frequent engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations. 52%
7. Continuation of the behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behavior. 63%

8. Need to increase the intensity, frequency, number, or risk of behaviors to achieve the desired effect, or diminished effect with continued behaviors at the same level of intensity, frequency, number or risk. 36%
9. Giving up or limiting of social, occupational or recreational activities because of the behavior. 51%
10. Distress, anxiety, restlessness, or irritability if unable to engage in the behavior. 55%

Another way to look at this data is to summarize the criteria for both sex addiction and sexual anorexia and contrast the percentages. Note that by structuring the criteria in parallel fashion they have similarities in terms of consequences, powerlessness, preoccupation and despair.

Sexual Addiction	**Sexual Anorexia**
Compulsive behavior (73%)	Compulsive deprivation (87%)
Loss of control (66%)	Excessive control (51%)
Efforts to stop (67%)	Efforts to avoid (29%)
Loss of time (58%)	Rigid, judgmental attitudes (48%)
Preoccupation (37%)	Preoccupation (44%)
Affects obligations (52%)	Affects obligations (52%)
Continue despite consequences (63%)	Extreme shame (73%)
Escalation (36%)	Despair (70%)
Losses (51%)	Intimacy avoidance (60%)
Distress (55%)	Distress (60%)

Eating disorder specialists have long made the case for compulsive overeating, bulimia, and food anorexia to be variations of the same illness. A growing number of them argue to understand them as part of the family of addictive disorders. Heubner (1993) describes food anorexia as having the same self-destructive psychological characteristics as drug addiction. He carefully summarizes the neurobiological evidence for a neurochemistry of food deprivation. He also notes the coincidence of sex addiction. By reviewing the above data, and the literature in other areas of addictive disorders, some key questions emerge: 1) can sexual addiction, sexual bingeing and purging, and sexual anorexia be considered manifestations of the same illness; 2) what are the core psychological and biological mechanisms that addicts and anorexics share; and 3) what common elements do eating disorders, sexual disorders, and other addictive and deprivation extremes share?

A family dimension also exists. Merl Fossum and Marilyn Mason wrote a classic on extremes in the family called *Facing Shame* (1986). Basically the authors talked about the key role of shame in these alternating cycles of "out of control" and "super control". Powerlessness and extreme rigidity were used to balance out family systems. Just as an extreme diet would lead to a binge, the shame of loss of control would cause one to jump back on the diet (a variation of the binge purge theme). Similarly as one family member would lose control, others would become super controlling in that area. Thus as a sex addict becomes more and more out of control, the spouse becomes increasingly shut down. As dysfunctional as that response might be, a certain "balance" to the system is restored. Bloom (1996) and others have noticed the same dynamic in whole cultures. For example, the extreme asceticism that occurred after traumatic events such as the black plague in the middle ages.

In contrasting sexual anorexics and sex addicts notice the histories of abuse, the presence of other addicts in the family, and the similar types of families (rigid and disengaged). In each of the cases described above notice that the anorexic was in the presence of one person or more whose sexuality was abusive or out of control. In fact, forty per cent of the anorexics in this study said their spouse was a sex addict and thirty-seven per cent of the sex addicts saw their spouses as sexually anorexic. So clearly the extremes identified within the intrapsychic system have reciprocal rhythms within the family system. The probable touchstone between the two systems is the interactive connection between family rules and personal belief systems. Nowhere does this become more clear than when a client fits the criteria for both sexual anorexia and sexual addiction.

Of the one hundred and forty-four sexual disordered patients, twenty-one, or fifteen per cent, were diagnosed as both sex addicted and sexual anorexic. Most sex addicts indicate that after acting out sexually they will feel despair even if momentarily. A little over half of the sex addicts in this sample said that after a binge there would be a period of time in which they had no sexual interest. The fifteen per cent who were assessed as having both conditions are those who are in a state of simultaneous binge purge. The coexistence of both states within the same person would tend to confirm that the illnesses have in part the same etiology and that they are manifestations of the same internal state.

This phenomenon has been recognized for some time. Butts (1992) and McCarthy (1994) described the coexistence of the two extremes in sex addicts. Manley (1991) expressed concern that recovery from sex addiction without attention to sexual health could simply be a switch to the anorexic side. Specific issues have also been identified with sexual deprivation, including paraphilias (Moser, 1992), fetishism (deSilva, 1993), and rape (Bownes and O'Gorman, 1991; Kanin, 1985). What we have lacked is a systematic way of diagnosing and measuring extremes. What follows is the case of Tim and Karen who both fit the criteria and yet were married to each other. Their situation illustrates the importance of being able to diagnose co-morbidity. Notice also the family dynamics.

Tim and Karen

Tim first came to treatment because of compulsive high risk sex with other men usually within porno stores. He also was seeing prostitutes and was experiencing severe financial problems as a result. With the men in the video booths and with the prostitutes he was having unprotected sex. He was married to Karen and had two children with her. Yet sex at its very best had been "matter of fact" and usually he avoided her. He reported loving her more than anyone else on the planet yet found sex with her repelling. He had these aversive feelings from the beginning of the relationship.

Karen was furious over Tim's behavior because of the betrayal and the high risk behavior. But as the story unfolded, she is an incest victim and was quite comfortable with the sexual status quo. She did not like having sex with Tim either. She also reported loving Tim deeply and wanting to remain married to him. Karen herself had a problem in that she was deeply involved with sex on the internet. She was dependent on the romantic intrigue of chat rooms and email. When Tim went to sleep she was on the computer ostensibly working, but really in a nightly cycle of chat rooms followed by phone sex. Karen was starting to meet these unknown men at a nearby beach and had several on-going affairs as a result. While outraged at Tim, Karen had difficulty at first seeing her behavior as also dangerous or high risk.

Both came from abusive families with other family members being addicted. Each had experienced some form of sexual trauma. Both had significant problems with alcohol and drugs. Both experienced their sexual issues more intensively once they entered recovery from their chemical dependency. Both reported a profound aversion to being sexual with the other despite

a deep emotional commitment. Both were acting out in high risk ways and they struggled with stopping those behaviors. Each saw the other as sexually rejecting. Both had contemplated suicide. Both thought they might have done it were it not for their two little girls.

Discussion

Around the turn of the 20th century internal combustion engines were starting to be used in a wide variety of applications including boats and farm machinery. Transmissions however were very primitive if existing at all. Still, many engines were easily reversed. If in a boat, you would stop the engine, spin the flywheel in the opposite direction, and the motor would run equally as well in reverse. The boat would travel in the opposite direction. In other words, the system was totally reversible. It just depended on which direction the initial spin went.

Perhaps this metaphor is apt for human systems as well. In sexual disorders, it appears that the system us reversible from one extreme to the other. Certainly in family disorders Olson (1983) and others have extensive documentation that opposite extremes can be switched one for the other and that opposite extremes have similar outcomes. In mental health however such an understanding of human systems requires a significant paradigm shift. This is especially true in those professions organized around one extreme or the other. For example, addiction specialists would have to start understanding the critical role of deprivation. Sexologists whose skills are developed to help people become more sexual have had problems switching to help people limit their behavior (Nathan, 1995). Similarly focusing on just one area such as eating disorders or alcoholism is insufficient since these extremes interact with the sexual extremes. It would appear that a new paradigm or "science" of the extremes is in order.

From an expanded paradigm, Tim and Karen's situation becomes more comprehensible. They stopped using alcohol and drugs and their sexual problems increased. The chemical extreme was replaced with the sexual extreme. While the specific sexual behaviors differed, they were like mirror images of each other. Karen had a major break through when she finally realized that meeting strange men on the beach for unprotected sex was not much different than strange men in video booths. Given their history and their families, their relationship and their parallel behaviors become much more comprehensible. Any "science of the extremes" and the measurement of any extreme behavior would have to take family and reciprocal trades into account.

This particular study points in that direction. The numbers are small, and the level of detail necessary to document the commonalities between sex addiction and sexual anorexia is not there. Moreover, the focus was to start the process of refining an expanded set of criteria for aversion desire disorder. The fact that eighty-nine per cent of the patients identified with at least three of the criteria as they stand is promising especially so early in treatment. This effort is preliminary to preparing a more detailed criteria analysis. Critical to such an effort would be an extensive follow-up to study how patients identified with the items as they progress through therapy. Concurrent validity would have to be measured with other measures of both sexual and addictive behavior.

Yet, the importance of such a potential analysis is clear. Acknowledging the extremes means that sex addiction therapists would have to take care that recovery is not simply stopping the engine and spinning the flywheel in a different direction. Family therapists would have to search for the reciprocating action of deprivation and addiction. All therapists would have to move to a "paradigm" of extremes, which could account for how illnesses become like interchangeable parts. Starting and stopping a behavior would no longer suffice as a measure of success. And for sexual anorexics themselves there would be relief at knowing how their obsession fits in the stream of things.

Conclusion

This paper reports early findings of a project to document criteria that would elaborate the conceptualization of aversion desire disorder or "sexual anorexia". The goal was to build the criteria on the basis of patient experience. Ten criteria were evolved as part of the sexual assessments of a residential treatment facility. This report involves 144 patients with extreme sexual disorders, sixty-one who fit the criteria for aversion desire disorder. They were given the expanded criteria of which eighty-nine per cent fit at least three. While promising, this data only suggests that a larger more detailed study would be useful. Only early treatment data was used, the sample size was relatively limited, and collateral validation needs to be established. Yet this data does support the suggestion that the criteria for aversion desire disorder could be usefully expanded. Clearly, a profile of the sexually anorexic patient is emerging.

By contrasting that profile with data from sex addicts who were in the same patient pool, some important contrasts can be made. The data for sex addicts and sexual anorexics were very parallel in terms of family system, abuse history, and related patterns of addiction, compulsion, and deprivation. Even the criteria for sex addiction and sexual anorexia have important parallels in terms of powerlessness, obsession, consequences, and distress. In fact, fifteen per cent of the patients fit the pattern for both sexual extremes. Such comparisons tend to confirm the proposition that extreme sexual disorders stem from many of the same factors and are variations of the same illness. Of equal importance is the possibility that extreme behaviors in various disorders (food, chemical, sexual, financial) whether in excess or in deprivation are for many patients interchangeable parts representing much deeper patterns of distress. If so, the implications are significant for many disciplines requiring perhaps a new "science of the extremes".

Case for Sexual Anorexia References

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