The Obsessive-Compulsive Model for Describing Compulsive Sexual Behavior

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Compulsive sexual behavior (CSB) is driven by anxiety reduction mechanisms rather than by sexual desire. CSB gives temporary relief to psychological stress, but continuing participation in the activity leads to even more distress. This paper outlines the arguments for using an obsessive-compulsive model rather than an addiction model for understanding and treating CSB. Although the term "sexual addiction" may be an interesting metaphor, CSB is likely to emerge as the preferred term and obsessive-compulsive disorder (OCD) the preferred model for understanding and treating this behavior.

Many terms have been used to describe the phenomenon of compulsive sexual behavior (CSB), including hypersexuality, nymphomania, satyrasis, promiscuity, and Don Juanism or Don Juanitism. Compulsive sexual behavior is defined here as behavior that is driven by anxiety reduction mechanisms rather than by sexual desire. The obsessive thoughts and compulsive behaviors serve the function of temporarily reducing anxiety and distress, but they create a self-perpetuating cycle. The sexual activity provides temporary relief, but it is followed by further psychological distress.

The subject of compulsive sexual behavior is drawing increased attention from both professional and lay audiences and is gaining at least as much interest as other sexual problems such as low sexual desire, inhibited sexual excitement, and the paraphilias. In the era of AIDS and renewed interest in intimacy in sexual relationships, disorders such as CSB are being carefully examined. However, there has been intense debate over whether the pathogenesis or dynamics of CSB is explained more accurately by the addiction model or the obsessive-compulsive model. The purpose of this paper is to provide some background of the debate and to describe the two models. The paper will describe the shortcomings of the addiction model and detail the rationale for the obsessive-compulsive model.

Development Of The Addiction Model

The lifetime disease concept of addiction, born in the 1960s, recognized that there was a medical explanation for the development of dependency upon certain substances—alcohol, amphetamines, barbiturates, and opiates, for example. Subsumed in the medical model, the addiction model asserted that these substances could become the agent of an addiction because their properties of physical dependence—increased tolerance and withdrawal symptoms—could be explained in terms of physical and neurochemical properties. Receptor sites were identified and found to be more plentiful and more "receptive" in individuals who became addicted.

In the 1970s, a looser definition of the term "addiction" developed and included certain behaviors that, in their excess, took on dynamics similar to those of drug addiction. Some researchers began describing destructive forms of eating, gambling, and sex as addictive behaviors. This made sense to many people because the lack of behavioral control associated with these disorders resembled the behavior of alcohol and drug addicts. Addiction became a popular metaphor. Twelve-step groups modeled after Alcoholics Anonymous were developed for behaviors that were judged to be excessive and were attended by individuals who felt a sense of "powerlessness" to overcome their behavior.

Overeaters Anonymous was one of the first of these groups to form, followed by others such as Gamblers Anonymous, Spenders Anonymous, Parents Anonymous (for child abusing parents)—and then Sex Addicts Anonymous, Sexaholics Anonymous, and Sex and Love Anonymous. Today there seems to be an "AA" type of self-help program for nearly every type of human ailment or condition. The definition of addiction is now so loose that Anne Wilson Schaef has described us as an "addictive society" made up of thousands of addicted individuals and organizations. Indeed, the model...
of addiction has become so overused and watered down that it has been rendered almost meaningless.

The model of sexual addiction has been scientifically unacceptable to many. Social scientists have reacted with chagrin to the conceptualization of these behavioral excesses as addictions or even as disease entities. Scientists have opposed this misconception primarily because there is no known interaction between a substance and the brain and because they think the original concept of the term “addiction” has been distorted beyond recognition or reason.

The Addiction Model as An Explanation Of CSB

Carnes has argued for the use of this broadened concept of addiction to describe CSB. And, when pressed to defend the use of the term “sexual addiction” in ways other than metaphor, Carnes argues the existence of the same interplay of biological, personality, environmental, and sociocultural factors one finds in alcohol or drug addiction. In terms of psychological factors, Carnes recognizes that there is little or no evidence that documents the association between CSB and psychobiological factors. He does cite the theoretical hypothesis that some individuals may be naturally addiction-prone to pleasure.

The hypothesized process of addiction to pleasure is explained by the opponent-process of addiction postulated by Richard Solomon. Solomon suggests that psychological and physiological responses of pain and pleasure can, in the right sequence, turn any individual into a pleasure “junkie.” This theory can explain some of the habitual patterns of drug-seeking (avoidance of negative reinforcement) as well as the reinforcing qualities of drug use (positive reinforcement). This theory parsimoniously accounts for major phenotypic characteristics of both pharmacologically and nonpharmacologically induced compulsive and repetitive behaviors related to addiction to psychoactive drugs. And for many alcohol and drug addicts, this interplay probably leads to a better understanding of the problem. However, although this theory may have some relevance for addiction to psychoactive drugs, there is no evidence that it can be applied to obsessive and compulsive sexual behaviors.

In addition, Carnes cites the theoretical framework of Milkman and Sunderwirth who have proposed a matrix of “addiction types” and the presence of various neurotransmitters that govern the electrochemical interaction of the synapses of the brain to explain the psychobiological connections among the various “addictions”—including sexual addiction. Certainly these theories can account for some of the psychobiological processes that might be involved in CSB, but they do not address the question of whether this psychoneurological approach fits the addiction model—and the known psychobiological factors involved. We must not lose sight of the fact that the addiction model and recent advances in understanding the addiction model are all predicated on the description of addiction with a psychoactive substance. (For further elaboration, see the special issue of the Journal of Abnormal Psychology on models of addiction.) So, in fact, the scientific models of addiction have not gone beyond explanations of addictions to psychoactive substances (e.g., alcohol, nicotine, cocaine) and, thus, cannot be

extended beyond metaphor to other areas in which the evidence is, at best, hypothetical.

The Dangers Of The Sexual Addiction Model

1) Inappropriate model application. The addiction theory lacks scientific substantiation, but more important, there are dangerous consequences to utilizing this model for CSB. The most obvious negative consequence is the inappropriate application of a model to the understanding of CSB. This has profound implications for the understanding, assessment, etiology, and treatment of CSB. As noted earlier, this complete adaptation of the addiction model to the treatment of CSB is questionable. The use of this approach has the potential of causing further damage to suffering individuals.

Many professionals see addiction and compulsivity as synonymous. Yet, the term “addiction” seems to be popular and easily grasped by the public and the media. Some professionals have easily succumbed to this oversimplification and have avoided careful examination of the appropriateness of this model as applied to CSB. This professional attitude is dangerous, since there are some fundamental differences between the two models that have profound implications.

Carnes does not seem to take this debate very seriously. For example, terms are used interchangeably throughout his book. He describes the main characteristics of sexual addiction as “obsession” and “compulsion.” For example, in describing sexual addiction, Carnes says, “Contrary to love, the obsessional illness transforms sex into the primary relationship or need, for which all else may be sacrificed, including family, friends, values, health, safety, and work.” He continues, “...[sexual addicts] exhibit a constellation of preferred sexual behaviors, arranged in a definite ritualized order, which are acted out in an obsessional scenario.” They [sexual addicts] “...experience little pleasure, often feeling despair even in the midst of sex.” Farther on, he describes the parallel between sexual addiction and eating disorders: “The most obvious common characteristic is our human capacity to take the most natural essential, and pleasurable life processes to the extreme of compulsive illness.”

When Carnes does distinguish between compulsion and addiction, he uses the term “sexual compulsion” to describe a component of the addictive cycle. His other components of the addiction cycle—preoccupation (obsessions), ritualization, shame, and despair—are also the same components in the description of an obsessive-compulsive disorder, but Carnes ignores this similarity. Carnes maintains that the addiction concept can describe this phenomenon better. He argues this because of the similarity of the symptoms or behaviors with those of alcohol and drug addiction.

2) Historical oversimplification of the addiction model. The addiction model has had a historical tendency to oversimplify a complex phenomena. Addictionologists are trying to overcome this historical oversimplification. However, unshakeable historical paradigms pervade: “Addiction is a disease that can only be treated by embracing the twelve-step program of spiritual recovery.” Recognition of concomitant psychiatric disorders and the treatment of those disorders with appropriate psychotropic medication is viewed with suspicion by those who fear that such
treatment will lead to a greater dependence on drugs. In addition, sociocultural factors and complex motivational factors are often seen as unnecessary diversions in the addicts' impaired thinking. A hallmark slogan of the traditional model is "keep it simple." This historical tendency thrwarts attempts to ask more complex questions, to view individuals as individuals, to take into account a multitude of biopsychosocial factors, and to develop individualized treatment approaches.

Arlene Boutin, a psychiatrist who presented a paper at the second National Conference on Sexual Compulsivity/Addiction,18 noted that the typical patient on the sexual dependency unit Carnes developed has obsessive-compulsive personality traits or disorders and that more than half the patients have a major depression problem. Many of them have had long-standing problems with depression. Boutin noted the "dramatic response" many of these patients show to anti-depressants, and she has found Prozac (tradename)—a serotoninergic anti-depressant—most effective. This pharmacological agent is effective in treating obsessive-compulsive disorders, including eating disorders. However, the use of psychotropic medication in treatment is never mentioned in Carnes's recent book.3

The fact that many of his patients are apparently treated with medication seriously confounds the understanding of Carnes's approach and his reliance on a twelve-step program for spiritual recovery. Although, spirituality is in some sense an indicator of psychological health, the lack of spirituality is often a symptom of OCD. When someone is obsessed, anxious, or depressed, it is nearly impossible for him or her to experience a sense of spirituality. Again, this fact may be ignored by Carnes because the traditional model of addiction has viewed the use of psychotropic medication with such great suspicion.

3) Failure to recognize the continuum concept of sexual behavior. Sexual behavior has been defined in a variety of ways.14-17 It is understood best when a continuum of behaviors is taken into account. The continuum concept is lost in both of Carnes's books.1,5 There are lengthy descriptions of "sexual addiction" with each of its three levels—culturally acceptable; nuisance; dangerous, abusive, life-threatening—on the one hand, and on the other hand, almost no description of "healthy" sexuality. The term "addiction" refers to a fundamental state that is invariable and somehow immutable. Once labeled, an individual is an "addict" for life. This is a dichotomous view, immersed in the traditional medical addiction model (i.e., addict-nonaddict), and is illustrated in Carnes's Sexual Addiction Screening Test (SAST).5 Thus, the SAST is designed to differentiate sexual addicts from nonaddicts. The questions are designed to elicit a "yes-no" response—again, reflecting this dichotomous view. Furthermore, the SAST fails to recognize cultural continua. The SAST is constructed to fit male, middle-class, Anglo-Saxon, and heterosexual norms of sexuality. Carnes even acknowledges that the test may not be as reliable with women and sexual minorities.

In addition, in Carnes's description of treatment, he does not address the problem of people who have developed abusive patterns. He only describes treatment for "addicts"—those in an "acute phase of the addiction." The reader is constantly forewarned that controlled or nonabusive behavior patterns may be just an after-effect or prelude to an acute phase. Carnes never recognizes that individuals may develop abusive patterns and revert to healthy patterns or never "progress" to an "acute phase of addiction." There is a distinct implication that once one enters the "initiation phase" or beginning phase of sexual addiction there is no turning back: the addict naturally progresses through a series of stages culminating in an "acute stage." The only way to interrupt this cycle, according to Carnes, is to admit to the addiction and follow his treatment guidelines. This reasoning follows the traditional addiction model, which emphasizes the embrace of the invariable and immutable illness—something one accepts and learns to live with through a spiritual program of recovery. One can be in "recovery" but never "recovered."

4) The dangers of the abstinence model of treatment. Although sexual abstinence is not the stated goal of Carnes's treatment approach, a "celibacy contract" is recommended as an important initial treatment strategy. The therapist asks the client to commit to a period of "celibacy;" usually twelve weeks long. Carnes defines celibacy as "...no sex with spouse and no masturbation." The "celibacy contract" thus might more accurately be described as a sexual abstinence contract. This treatment prescription sounds reminiscent of the sexual messages that have caused many people much sexual dysphoria in the first place. Sex is dangerous (dirty), save it for the one you love (and make sure it is heterosexual, loving, committed, and monogamous relationship). It is easy to see how people consider Carnes's sexual attitudes as restrictive, morallist, homophbic, and heterosexual.

Although Carnes illustrates the benefits of the "celibacy contract," one also has to be concerned about the damaging effects of this intervention. Since CSB has been linked to restrictive attitudes regarding sexuality, this intervention reinforces this attitude—and perpetuates the problem. Thus, according to a systems analysis of the "addiction models," parts of the treatment approach seem to reinforce the dysfunctional dynamics underlying the problem.

An emphasis on positive approaches to sexuality is missing in the addictive model of CSB. Although Carnes compares "sexual addiction" to eating disorders, he notes that fasting is not required of individuals in an initial phase of treatment. So why is abstinence required in the initial phase of sexual addiction treatment? One can only speculate that the traditional model of alcohol addiction pervades here—as well as the possession of restrictive attitudes about sexuality. Although Carnes states that sexual health is the ultimate goal of treatment, the teaching of health sexuality is granted only six lines in his 280 page book.5 Many more pages are devoted to "celibacy contracts," elimination of compulsive patterns, and methods of avoiding "slips" (relapse prevention). This approach may be helpful to some, but the addiction model forces the imbalance of therapeutic emphasis.

It is interesting that Carnes5 cites Orford's guidelines9 for an enlightened model of sexual addiction. Orford thought it was important to recognize the wide range of sexual behavior, the concept of a continuum of sexual behavior, cultural differences, positive prin-
The Obsessive-Compulsive Model for Describing CSB

CSB can be described more accurately as a symptom of an underlying obsessive-compulsive disorder in which the anxiety-driven behavior happens to be sexual in nature. Symptomatically, individuals may describe generalized anxiety, dysthymia, panic-attacks, obsessive thoughts, and/or compulsive drives. They also may feel "out of control" in relation to sex. They usually complain of a long-standing, chronic pattern of anxiety or low-grade depression with peaks of acute anxiety or depression. Patients often meet Diagnostic and Statistical Manual of Mental Disorders (DSM III-R) criteria for either a generalized anxiety disorder or dysthymia. Most clinicians agree that obsessions and compulsions lead to secondary feelings of anxiety and depression.

In classic obsessive-compulsive disorders (OCD), the obsession and compulsion revolves around an unpleasant activity, yet the individual is compelled to engage in that activity or suffer extreme anxiety. Obsessions are unpleasant because they are manifestations that one's thoughts are out of control. Since sexual behavior is often experienced as a pleasurable activity, some have argued that CSB does not meet the strict diagnostic criteria for OCD. However, individuals with CSB rarely report pleasure in their obsessions or compulsive behavior. They also know that their recurrent thoughts or behaviors are senseless or distasteful, an important distinguishing variable between normal sexual behavior and CSB. Therefore, CSB should be viewed as a variant of OCD—a view shared by some of the leading researchers of anxiety and OCD. For example, Jenike states, "A number of other disorders may be related to obsessive-compulsive disorder, among them bowel and urinary obsessions, eating disorders, compulsive gambling, compulsive sexual behaviors, body dysmorphic syndrome, and monosymptomatic hypochondriasis." Individuals with CSB describe a sexual act as a "fix" that relieves feelings of anxiety or depression or obsessional thoughts. The relief, however, is short-lived, and negative feelings recur, compelling the individuals to seek relief again. This kind of experience is common and is described by people with a variety of obsessive-compulsive disorders. This anxiety disorder may be responsible for or exist in conjunction with a psychosexual disorder. Currently the term "sexual addiction" is used in DSM III-R to describe a type of psychosexual disorder not elsewhere classified (302.90). This is the only place in DSM III-R that the term addiction is used—and it is applied to sex. This is an unfortunate misnomer, and this term should be changed in the next revision of the manual. There seems to be a growing consensus that a classification of nonparaphilic compulsive behavior be included in the list of psychosexual disorders. Insofar as psychosexual disorders are distinguished from other psychiatric disorders, it seems appropriate to list the two types of compulsive sexual behaviors (normophilic and paraphilic) in the list of psychosexual disorders. Despite the difficulties of separating normophilic and paraphilic disorders, because of the assumed sociocultural influences, they should be preserved as psychosexual disorders because of their interference in psychosexual and intimacy functioning and the similar OCD dynamics.

The Development of CSB

Sexual compulsivity has been linked to early childhood trauma or abuse, highly restrictive environments in relation to sexuality and intimacy, and low self-esteem. Besides these psychological factors, the influence of sociocultural and biological factors are recognized as well. These factors may be precursors or signs of some form of obsessive-compulsive disorder. It has been hypothesized that these difficulties are manifested not only in behavior but also in neuropsychiatric or neurophysiological abnormalities. Furthermore, it has been hypothesized that the loss of control in behavior patterns may be due to abnormalities in the basal ganglia and/or the prefrontal cortex of the brain. Rapoport speculates that obsessional thoughts may be exaggerations of drives that may be "hardwired" in the neuron function of the brain and that may explain their resistance to change.

Substantial evidence exists to support the hypothesis that a neurological basis exists in the obsessive-compulsive model. Positron-emission-tomographic (PET) scans of patients with classic OCD have shown abnormalities of glucose metabolism in the limbic cortex and the basal ganglia of the frontal cortex of the brain when compared to depressed persons and normal control subjects. Furthermore, when patients receive serotonergic-enhancing medication, PET scans detect that the glucose metabolism in the brain resembles that of normal individuals, and obsessive-compulsive behavior is eliminated or dramatically reduced. Rapoport has suggested that there may be a constellation of psychiatric problems that do not manifest the full features of OCD but may respond to antiobsessional medications such as clomipramine, as demonstrated in the treatment of trichotillomania (compulsive hair pulling). Jenike hypothesizes that because OCD responds to serotoninergic drugs, but not to adrenergic agents such as imipramine, similar mechanisms are involved. This combination of findings lends support to the aforementioned hypotheses and suggests an important neurological component to OCD.

The integration of these factors is illustrated in the work of Česnik and Coleman in the treatment of CSB. Thus, CSB could result from a biological predisposition or could develop as a result of environmental stress. A combination of factors is probably involved in the development of obsessive-compulsive disorders, as is the case with many other psychiatric problems.

Treatment of CSB as an OCD Disorder

This theoretical model can lead to clearer understanding of CSB and the development of more effective treatment methods. Using some of the recent advances in the understanding and treatment of OCD, effective treatment techniques have been developed that use pharmacological therapy together with psychological...
therapies. These techniques involve presynaptic serotonergic drugs combined with psychological treatment that encompasses psychodynamic, behavioral, and client-centered therapeutic models. Previously, these psychological therapies were only marginally successful in treating OCD. But now these techniques have been enhanced greatly by recognizing the importance of the biomedical correlates and by utilizing appropriate pharmacological agents.

There is a continuum of severity to this disorder. Therefore, some patients respond to brief interventions and do not require medication. Understanding the severity of the OCD can lead to individualized treatment; some treatments might require psychological or psychoeducational interventions and others might require psychotherapy combined with prescription of psychotropic medication.

The Importance Of Biomedical Correlates And Pharmacological Treatment

As noted earlier, the symptoms of OCD are refractory to traditional psychotherapy but often respond dramatically to specific drugs. In severe cases, this might suggest that an underlying biologic dysfunction may be at the root of the disorder, and, thus, a biomedical treatment approach would be a keystone of treatment. This is an important difference between the two models of treating CSB. The use of medication is often viewed as heresy in the traditional addiction model. Recently, however, we have found that serotonergic pharmacological medications are quite effective in interrupting the obsessive-compulsive cycle of CSB when accompanied by these psychotherapeutic methods. These medications are very effective in interrupting the obsessive-compulsive cycle, and patients have been able to engage in therapy more effectively. The results have been more successful than with individual, family, or group therapy treatments alone. For example, we have successfully used lithium carbonate, which has been demonstrated to enhance presynaptic serotonergic functioning, to treat CSB. Lithium may have specific effects on the limbic cortex and possibly on the basal ganglia of the frontal lobe. This explains why lithium has also been shown to have some effectiveness in treating obsessive-compulsive disorders, especially in resistant cases. The use of fluoxetine (Prozac) has also proved effective. These findings constitute a breakthrough in the treatment of OCD, which previously had been an extremely difficult disorder to treat successfully. Now a similar model has given hope to many who suffer from CSB.

Summary

CSB is a term that describes the dynamics of abusive behaviors that serve to relieve psychological stress but that lead to further activity and more psychological distress. The OCD model of treatment of CSB is fundamentally different from the model that describes CSB as a "sexual addiction." Although the term "addiction" may be an interesting metaphor, it obviates the essential understanding of the etiology of CSB. Advocates of the term "sexual addiction" rely on a treatment approach—a twelve-step program—similar to the one that has been found effective in treating alcoholism. They advocate that sexual addiction creates a spiritual dis-

ease and that recovery involves a program of spiritual recovery. Because this is an inappropriate application of the addiction model, there are dangerous consequences for individuals seeking help for CSB.

The OCD model of CSB has several advantages over the addiction model. First, the term CSB is more descriptive of the behavior and the underlying processes. Second, it recognizes that any sexual behavior can become an agent of compulsive behavior. Third, the term is not tied to either psychological or biological causes but allows a more systematic basis for CSB to be postulated. Fourth, there is a recognition of a continuum of severity of compulsions. Fifth, the obsessive thoughts or the compulsive behavior seem to serve as a way of relieving stress. Sixth, it allows for a greater range of treatments to be employed. And, finally, there are theoretical explanations that can encompass personality, biological, environmental, and sociocultural variables. For all these reasons, CSB is likely to emerge as the preferred terminology and OCD the preferred model for understanding and treating this behavior.

References


