

## **Classifying Problematic Sexual Behaviors—It’s All in the Name**

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Problematic sexual behaviors have been identified for centuries. Terms such as nymphomania (Erickson, 1945), satyriasis (Allen, 1969), and Don Juanism (Stoller, 1975) have been prevalent in literature, scientific writings and pop culture. The current debate on what to call individuals who struggle with problematic sexual behaviors stems around comparison with other DSM-IV-TR recognized disorders. Proposed terminology includes Sexual Addiction, Compulsive Sexual Behaviors, and variants of Impulse Control Disorders and even Obsessive Compulsive Disorder.

The current scientific literature has favored Hypersexual Disorder for several reasons. Hypersexual Disorder is meant to represent a non-pejorative/neutral descriptor for those with increased sex drive due to (a currently unknown) primary process (Kafka, 2010; Stein, 2008). The idea is that hypersexuality falls on a spectrum of sexual desire—ranging from the low end (hyposexual disorder) to the high end (hypersexual disorder) with multiple possible etiologies (Kafka, 2010). Since hypersexuality is a symptom with many possible etiologies, certain modifiers have been proposed. For example, an individual may be hypersexual due to cocaine (e.g. “Substance Induced Hypersexual Behavior”) or a tumor (“Hypersexual Behavior Due to A General Medical Condition”). The great majority of individuals whose repetitive sexual behavior was not the result of a medical condition or substance would hence fall into the category of Hypersexual Disorder.

The main argument for this term is that other terms (e.g., compulsive, impulsive, addictive) insinuate other DSM-IV disorders. Yet, the inclusion of problematic sexual behaviors as part of those disorders cannot currently be justified due to lack of knowledge about the etiology (Kafka, 2010; Stein, 2008). For example, the term compulsion seems misguided since the sex addicted individual gains “reward” from the activity and does not necessarily have a reduction in anxiety as seen with classic compulsive behaviors such as hand-washing, hair pulling and checking behaviors, etc. (APA, 2000; Kafka, 2010; Stein, 2008). Furthermore, the pathophysiology of sexual problems and Obsessive Compulsive Disorder appears to be quite distinct (Stein, 2008).

Impulse Control Disorder NOS is also problematic since such terminology would classify disorders of sex, a primary drive, in an arena where no other primary drives are found. For example, individuals who eat, drink, or sleep too much are not classified as having impulse control disorders (Kafka, 2010) even when their behaviors cause significant distress or impairment. Furthermore, such terminology goes against the meticulous planning, sex seeking behaviors, and prodrome of fantasies, urges and behaviors seen in many individuals who suffer from problematic sexual behaviors (Kafka, 2010; Stein, 2008).

Probably, the most challenging debate has centered around the term Sexual Addiction. Given the title of this journal, it is worth spending time looking at the arguments for and against it. The current DSM categorizations do not include addiction as a mental disorder, but rather distinguishes chemical dependence from abuse (APA, 2000). The reasons for not including addiction include the fact that the word is vague, overused, misused, clinically inaccurate and stigmatizing. Further it does not distinguish between the “disease” model and those individuals who simply misuse or abuse a substance (Erikson & Wilcox, 2006). Yet, researchers and clinicians have long recognized that individuals experience similar affective dysregulation, behavioral inhibition, and reward for behavioral “addictions” as they do to chemicals (Goodman, 2008). Furthermore, there is some evidence for similar pathophysiological and psychodevelopmental processes (Frost et al., 1986; Schwartz, 2008). Yet, to date, withdrawal and tolerance, a central component of chemical dependence, to sexual behavior has not been adequately validated outside of descriptive literature (Kafka, 2010).

It may seem petty to argue over the name of a disorder, as long as the clinical criteria are valid and reliable indicators of the disease process. And indeed, the proposed criteria include similar criteria to chemical dependence in terms of time, relation to affect, loss of control, and continuance despite negative consequences. Yet, there is something about the term Hypersexual Disorder that fails to capture the experience of those who suffer from the disorder.

There are a multitude of diseases that represent “hyper” states in medicine—primary hypersomnia, hyperphagia, hyperaldosteronism, and hyperthyroidism to name a few. While each of these disorders represents a dysregulation of normal biological processes, the experience of an individual with increased sexual appetite qualitatively differs from any of these. Rather than simply being an upregulation in sexual drive, the sex addict experiences loss of control, behavioral reinforcement (reward), affective dysregulation, and impairment in cognitive and executive functioning. Such cognitive and behavioral effects are simply not found in the other mentioned disorders, even when the substrate being upregulated can have direct effects on the brain.

The purpose of this editorial is not to throw punches at the current proposed DSM-V disorder. Rather, it is to critically examine the continued use of the term Sexual Addiction in our work and our title. Simply because the lay public misuses or does not understand a clinical term, does not mean that the term is not valid. Rather, it is our job as researchers and clinicians to continue educating the public in the appropriate use of the term and to apply scientific rigor to its definition and use. The psychiatric community has not thrown away “Schizophrenia” despite widely misheld beliefs and inaccurate portrayals of violence and split personalities. And indeed, we have come a long way in helping both the public and even the scientific community move away from viewing addictive processes as a choice, but rather in the context of a disease model. It is for this very reason, the journal will continue to accept and use Sexual Addiction as a valid clinical descriptor until our understanding of the pathophysiological and psychodevelopmental processes present with a more clinically accurate term.

In the next issue, I will elaborate on important biological, psychodevelopmental, and social research and theory that further illustrate the validity of conceptualizing Sexual Addiction in the addictive spectrum of disorders. I look forward to featuring the work of many of our contributing authors in providing one of the most up-to-date and comprehensive reviews of our field.

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