Sexual addiction and paraphilias

Sexual Addiction and Paraphilias

Abstract

Sexual addictions are regarded by sex-addiction professionals as a real disorders with real problems for the addict if left untreated. Most sexual addictions are non-paraphillic in nature but some sex addicts engage in paraphilic behavior. A paraphilia is a sexual act which becomes intensified when the addict engages in sexual activities with objects, situations, or even people that are considered to be atypical or abnormal in nature of sexual behavior. The APA has not provided unique diagnostic criteria for sexual addiction to be its own disorder. Instead the APA's DSM-5 lists this disorder as a condition under the category of Hypersexual Disorders. This student will define sexual addiction and Hypersexual disorder as well as relate how paraphilia can be considered as a congruent sexual behavior of sexual addiction. This paper will discuss how sexual addiction (i. e, Hypersexual disorder) and paraphilia are connected as well discuss the diagnostic criteria and treatment for them as sexual disorders.

Keywords: Hypersexual, Sexual addiction, Paraphilias, DSM-V, diagnostic criteria, treatment

Sexual Addiction and Paraphilias

The Greek prefix " hyper" can be defined as being " over, above, or excessive". Any activity can considered " hyper" if the person increased his/her behavior in a manner that is pathological or dysfunctional to their lifestyle or overall health. If one looks in the DSM-5 manual, one will not find

any definition for the term " sexual addiction". The only category that is listed in the DSM-5 is that of " Paraphilias" (American Psychiatric Association, 2013, p. 685). Sexual addiction has been theorized as being a sex-related condition of a Hypersexual disorder. The purpose of this paper is to examine how paraphilias are related to sexuality, hypersexuality, and sexual addiction.

According to Birchard (2011), sexual Addiction is " not listed in DSM IV TR but it did get a side mention in DSM Ill R" (p. 160). He notes that it was dropped when the DSM-IV came out after the DSM-III R. Birchard (2011) defines defines sexual addiction as a " pathological sexuality as made up of recurrent, intensely arousing fantasies, urges, and behaviors involving normative and/or nonnormative aspects of sexual expression that cause distress or psychosocial impairment" (p. 163). He also goes to call sexual addiction as being a part of hypersexuality but then discusses how addiction fits the phenomena that one experiences from hypersexual behavior, Birchard (2011) notes that there " are a number of objections to the concept of sexual addiction" (p. 165) as being a disorder based on definition, differences in patterns of behavior, and lack in the language and rationalization of analysis from a psychological and psychiatric standpoint.

According to Turner, Schöttle, Bradford, and Briken (2014), they state that " sexual addiction, sexual compulsivity, sexual preoccupation, and hypersexuality have been used to describe hypersexual behaviors in an individual, clarifying that the cause of hypersexual behaviors was and still is controversial" (p. 413). It is hard to for therapists to determine hypersexuality or sexual addiction as a problem when the APA will not

recognize it as a true disorder warranting attention. Kafta (2009, 2010) states that Hypersexual Disorder would be " proposed as a new psychiatric disorder for consideration in the Sexual Disorders section for DSM-V" (p. 377). He characterized this new disorder similarly to what one would find as a sexual addiction today. Hypersexual disorder can be diagnosed as being a pattern where the person becomes preoccupied in sexual activities that are repetitive, intense in behavior, and also involve sexual fantasies. A person suffering from a hypersexual disorder would find that he/she has significant impairment in life" personally, socially, and occupationally. For a person who has Hypersexual disorder, any attempts to control the symptoms or behavior would be unsuccessful due to the intensity to want to engage in the sexual activities, and sexual urges would become hard to diminish as the sexual behavior increased. Hypersexual activities act as the person's method of dealing with daily life stressors and/or unpleasant state of mind.

This student did not find any information in the DSM-5 on hypersexuality as being its own disorder or category. Sexual addiction would be a component of Hypersexual disorder as that it is a condition where the addict is preoccupied with sexual behaviors and thoughts to achieve a desired sexual reward. Sexual addiction also comes with negative consequences and impacts the addict's daily life: personally, socially, and even at his/her employment.

Paraphilias and Paraphilic Disorders

Paraphilic disorders are divided into two categories: paraphilic or nonparaphilic. The DSM-5 classifies some paraphilic sexual disorders

under302. 9(F65. 9) Unspecified Paraphilic Disorder (American Psychiatric Association, 2013, p. 705) if they do not meet certain criteria. The DSM-5 states that there is a clear distinction between paraphilias and paraphilic disorders. The DSM-5 discusses how a paraphilia is a sexual interest that is " greater than or equal to normophillic sexual interests" (American Psychiatric Association, 2013, p. 685). Most paraphilias themselves would not require treatment do not require whereas a paraphilic disorder would. Paraphilic disorders are divided into two categories: paraphilic or nonparaphilic. According to the DSM-5, a paraphilic disorder as " a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others" (American Psychiatric Association, 2013, p. 685-686). There are eight classified paraphilic disorders listed in the DSM-5 (i. e., voyeurism, exhibitionism, Frotteuristic disorder, sexual masochism, sexual sadism, pedophilic disorder, fetishism, and transvestic disorder) as well as two sub-categories: other specified and unspecified paraphilias.

Pedophilia involves having sex with a child (of any age) and has become one of the most common types of paraphilias coinciding with sex addiction. Sometimes a pedophile has a preference for a certain age group or gender. It is not uncommon for even a pedophile to engage in sexual activity with their own family members (e. g. children, stepchildren, nephews/nieces). Fetishism develops when a person derives sexual pleasure from a specific object such as a shoe, underwear or other nonliving objects. A fetish addiction does not always require having human interaction unless the addict is aroused by a human body part. Frotteurism is less common as a

paraphilic sex addiction and involves the addict rubbing up against or touching/fondling a person without consent.

Sexual sadism involves causing pain or humiliation to another person and beings sexually aroused by the sexual act. The " victim" can even be a consenting participant. Sexual sadism as an addiction causes the sadist to increase the sexual pain in order to become sexually satisfied which leads to violent acts such as torture, rape and even murder. Sexual Masochism is the exact opposite of sexual sadism. A sexual masochist may even partner up with a sadist to achieve sexual satisfaction as they need humiliation or pain to obtain sexual arousal. Voyeurism is when a person spies on an unsuspecting person and becomes sexually excited by observing an intimate act such as bathing or sleeping. Exhibitionism is the paraphilic sex addiction where the sex addict exposes their genitals to a complete stranger and becomes sexually aroused by the stranger's reaction. An exhibitionist may even engage in masturbation to achieve sexual satiation. Transvestism is where a person dresses up in the opposite gender's clothing in order to achieve sexual gratification. A transvestite may even engage in sexual activity with sexual partners while dressed in the clothing style of the gender he or she may want to portray.

Kafka (1996) states that paraphilias were defined by the DSM-IV as being " sexual impulse disorders characterized by intensely arousing, recurrent sexual fantasies, urges and behaviors (of at least six months' duration)" (p. 1). Paraphilias generally occur with males and although most paraphilias are associated with aggressiveness and/or harm, there are some paraphilias that are not such as fetishism or transvestic disorder. There are a few rare cases

of paraphilias being seen in women but there is little research being conducted on how women become paraphilic in sexuality much as there has been little research with women having sexual addictions or hypersexuality.

Etiology of Sexual Addiction and Paraphilias

There are many theories to how a person becomes sexually addicted and/or develops a paraphilia. According to Birchard (2011), there is a " relationship between sexual addiction and the paraphilias" (p. 157). Birchard also explores in depth as he discusses how sexual addiction could be more than a concept. Birchard (2011) states that " sexual addiction and the paraphilias are 'located in the wider framework of the psychoanalytic theory of perversion'" (p. 157). He believes that perversion and sexuality are linked together due to a single causative agent like childhood sexual trauma/abuse which turns into pleasurable events that become sexual addiction and paraphilias. Birchard (2011) states that " traumatic events in childhood are reversed and, according to Opponent Process Theory, are made pleasurable by eroticization. The outcome: the painful is made pleasurable, the unbearable made bearable" (p. 174). Childhood trauma could very likely be a cause for a person to develop a sexual addiction or paraphilia. Another cause could be physical trauma. Ullman (2007) states that there is " evidence of prefrontal cortical damage in sexual addicts with a history of sexual trauma" (as cited in Samenow, 2010, p. 293). Another approach is to use of the biopsychosocial model in order to determine the physical, psychological, and social causes for sexual addiction and paraphilia. Samenow (2010) discusses how he will use " the biopsychosocial model as a framework for presenting what is currently known about hypersexual disorder from the scientific

literature" (p. 70) There could be a biological reason for why a person develops a sexual addiction or paraphilia. Birchard (2011) states that " behind addictive compulsive sexual activity there lies a biological mandate. Men and women are created to be sexual. Sexuality is central to their identity and to their behavior" (p. 167). So sexual addiction and paraphilia could be caused by an ingrain biological component to one's sexuality.

Paraphilias have also changed over time. Homosexuality was once considered to be a paraphilia buy now is regarded as a normal sexual state of mind. Masturbation was also considered to be a sinful deviant sexual act but has become normalized over time in society. One should note that a person never chooses to become addicted to sex or have a paraphilia.

The Correlation between Sexual Addiction and Paraphilias

Why do some people develop sexual addictions and paraphilias? If a person can develop a sexual addiction and/or paraphilia due to childhood trauma or biological components, there must be a connection between the two conditions. According to Birchard (2011), it is:

" the function of sexual addiction to relieve the effect of intolerable affects. It is to relieve depression and anxiety. It is to mitigate and reverse the affective outcomes of narcissistic damage. It is a conversion process, changing distress into pleasurable intensity" (p. 175).

Birchard discusses how pleasure becomes derived from trauma and that " paraphilia also acts to change trauma into pleasure" (Birchard, 2011, p. 175).

Trauma can also cause a sexual addict to seek pleasure from sexual acts once deemed harmful.

Diagnosis of Hypersexuality (Sexual Addiction) and Paraphilias

According to Turner, Schöttle, Bradford, and Briken (2014), there are several " instruments currently in use for the assessment of hypersexual behaviors or hypersexual disorders were developed in the North American or European countries" (p. 415). One such instrument is the Sexual Compulsivity Scale (SCS) which is a psychometric assessment consisting of 10 items which measures the levels of hypersexuality and sexual addiction. The purpose of the SCS is to predict the rates, variety, and practices of a person's sexual behaviors, the number of partners he/she has been sexual with, and if there is a history of STDs. Turner et al (2014) found that " the SCS positively correlated with sexual sensation seeking, number of sexual partners, and participation in risky sexual behaviors" (p. 415). Another assessment that can be used is the Hypersexual Behavior Inventory (HBI). The HBI consists of " 19 items and measures hypersexual behaviors on three factors: control, coping, and consequences, showing good psychometric properties in treatment-seeking hypersexual men" (Turner et al, 2014, p. 415). The HBI and SCS have a positive correlation with one another in terms of their total scores in sexual behaviors. One example of correlativity was that both tests had similar positive results with the subcategories of masturbation frequency and number of sexual partners. Lastly, a therapist can use the Hypersexual Disorder Screening Inventory (HDSI) scale to measure a client/patient for hypersexuality. According to Turner, Schöttle, Bradford, and Briken (2014), this assessment was " developed by the DSM-5 Workgroup committee and

includes seven items divided in two sections (section A: recurrent and intense sexual fantasies, urges and behaviors; factor B: distress and impairment as a result of these fantasies, urges, and behaviors)" (p. 415). The reason behind the HDSI was to develop an inventory assessment that would test for hypersexual behaviors based on criteria that could be used by the DMS-5 to make hypersexuality a new disorder in the manual.

Turner et al. (2014) state that " clinical assessments are susceptible to socially desirable answering and impression management limiting the diagnostic validity of clinical judgments" (p. 419). Validity is important to the diagnostic process of disorders and the use of assessment instruments become more frequently used due to their validity and reliability. Assessment instruments are considered to be " more objective, less vulnerable to deception, and could thus be considered as one useful addition to support clinical diagnostics" (Turner et al., 2014, p. 419).

Treatment of Hypersexuality (Sexual Addiction) and Paraphilias

Many clinicians believe that paraphilic disorders cannot be changed. Therefore, they set a goal for the paraphilic to have therapy that can reduce one's discomfort with paraphilia as well as limit any type of behavior that can become criminal in nature. The most common forms of treatment are psychotherapy and medication. In the most severe cases of paraphilic disorder, antiandrogens have been used as a form of medical castration.

One form of psychotherapy is for the therapist to use cognitive behavior therapy to treat paraphilias. According to Kaplan and Krueger (2012), the " principle treatment approach of behavior therapy for paraphilias is to

eliminate the pattern of sexual arousal to deviant fantasy by assisting the patient with decreasing inappropriate sexual arousal" (p. 292). They discuss several methods to use in order to disrupt the paraphilic behavior such as covert sensitization, satiation (through masturbation), and systematic desensitization. According to Kaplan and Krueger (2012), there is a second part to the CBT treatment for a clinician to use for " individuals with paraphilias is to assist the patient with enhancing sexual interest and arousal to adult partners or to appropriate behavior with adult partners" (p. 293). Kaplan and Krueger (2012) mention orgasmic reconditioning and fading as therapeutic techniques to be used in this part of CBT therapy (p. 293). It is believed that CBT can help those affected by paraphilia and paraphilia disorder by having them develop new strategies to cope with the disorder, their sexual behaviors, and avoid the triggers or stressors that cause the person to act out their sexual interests. Lastly, CBT is considered to be the only form of psychotherapy that can be currently used with patients who suffer from paraphilias due to the fact that CBT is empirically supported by psychological research.

There are many pharmacological medications used to treat paraphilias and sexual addiction. According to Turner et al. (2014), medications can " aim at a reduction of the sexual drive, sexual preoccupation or sexual impulsivity" (p. 419). Medicine has been shown to help paraphilics control their sexual urges or behavior. It cannot help a person change their behavior or become normalized as paraphilia is considered to be a condition that biological and psychological in nature. Unlike losing weight if one becomes overweight, a

person cannot lose the ability to be paraphilic in nature. One can change the way one thinks sexually through treatment.

Saleh (2005) described his work with leuprolide acetate and a young sex offender who after treatment found " his sexual drive and his urge to expose himself diminished significantly" (p. 434). Leuprolide acetate has shown to be able to reduce sexual behavior and even arousal in people who suffer from paraphilias. Krueger and Kaplan (2001) found that " leuprolide acetate resulted in a significant suppression of deviant sexual interests and behavior as measured by self-report and was well tolerated" (p. 409). There are many other types of medications that can be used to treat paraphilias such as SSRIs. Kafka (1996) states that " SRIs are the primary biological treatments for sex offenders and men and women with paraphilia-related disorders" (p. 3). Usually a person with paraphilia will be prescribed medication and treated with CBT to get the best treatment course and effect.

Another form of treatment for a sexual addiction and paraphilia would be to enlist the person into a 12 step treatment program such as Sex Addicts Anonymous (SAA) and Sexaholics Anonymous (SA). Both types of treatment programs can be offered as individual treatments or within group sessions. There has been evidence that 12-step programs have shown to be helpful in treating sexual addicts and paraphilia.

Conclusion

There may be different forms of trauma which could cause a person to develop a sexual addiction and/or paraphilia. Paraphilias do not arise due to normal development (e. g., physical, emotional, and psychological) as well as

normal sexual behavior. One can develop a paraphilia while engaging in sexual addictive behaviors. Although the DSM-5 has not classified sexual addiction as its own disorder paraphilias are. One can either have a paraphilia or a paraphilic disorder. There are many valid diagnostic tools to determine if a person suffers from a sexual addiction and paraphilia. Treatments can range but CBT with medication seems to be the most effective course of action. This student has found the research information as well as discussions on paraphilias and sex-addiction to be most interesting. Hopefully, more research will be conducted which could list sex-addiction as a " real" disorder.

References:

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Birchard, T. (2011). Sexual addiction and the paraphilias. *Sexual Addiction & Compulsivity, 18* (3), 157-187. doi: 10. 1080/10720162. 2011. 606674

First, M. B. (2014). DSM-5 and Paraphilic Disorders. *Journal of the American Academy of Psychiatry and the Law Online* , *42* (2) 191-201. Retrieved February 13, 2017 from http://jaapl. org/content/42/2/191. full

Hypersexual Disorders (2012). Paraphilias and Sex Addiction. Retrieved February 15, 2017 from http://www. hypersexualdisorders. com/sex-addiction/paraphilias-and-sex-addiction/

Kafka, M. P. (1996). Therapy for Sexual Impulsivity: The Paraphilias and Paraphilia-Related Disorders. Psychiatric Times, 1-4. Retrieved from

http://www. psychiatrictimes. com/articles/therapy-sexual-impulsivity-paraphilias-and-paraphilia-related-disorders

Kafka, M. P. (1997). Hypersexual desire in males: An operational definition and clinical implications for males with paraphilias and paraphilia-related disorders. *Archives of Sexual Behavior, 26* (5), 505-526. doi: 10. 1023/A: 1024507922470

Kaplan, M. S., PhD., & Krueger, R. B., M. D. (2012). Cognitive-behavioral treatment of the paraphilias. *The Israel Journal of Psychiatry and Related Sciences, 49* (4), 291-296. Retrieved from http://ezproxy. liberty. edu/login? url= http://search. proquest. com. ezproxy. liberty. edu/docview/1777659222? accountid= 12085

Krueger, R. B. and Kaplan, M. S. (2001). Depot-Leuprolide Acetate for Treatment of Paraphilias: A Report of Twelve Cases. *Archives of Sexual Behavior, 30* (4), 409-422.

Saleh, F. (2005). A hypersexual paraphilic patient treated with leuprolide acetate: A single case report. *Journal of Sex & Marital Therapy, 31* (5), 433-444. doi: 10. 1080/00926230591006782

Samenow, C. P.(2010). A Biopsychosocial Model of Hypersexual Disorder/Sexual Addiction. *Sexual Addiction & Compulsivity* , *17* (2), 69-81. doi: 10. 1080/10720162. 2010. 481300

Turner, D., Schöttle, D., Bradford, J., & Briken, P. (2014). Assessment methods and management of hypersexuality and paraphilic disorders.

Current Opinion in Psychiatry, 27 (6), 413-422. doi: 10. 1097/YCO.

0000000000000099