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Diagnosis and Treatment of Sexual Addiction: A Survey among German Sex Therapists

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Controversies exist about the diagnostic concept of "sexual addiction." The aim of this study was to investigate if German specialized sex therapists are confronted with patients who possess sexual addiction symptoms and to obtain information about diagnoses, comorbidity and treatment. A 12-item questionnaire was sent to all members of the German Society of Sex Research asking them about diagnoses, comorbidity and treatment of patients who experienced sexual addiction problems. Forty-three out of 149 members (28.9%) responded to the survey and reported about 97 patients with sexual addiction symptoms. Most common were pornography dependence, compulsive masturbation, and protracted promiscuity. Using ICD-10 definition "excessive sexual drive" was diagnosed more often in women while "disorder of sexual preference" was mainly diagnosed in men. In women neurotic (e.g., anxiety disorders) and eating disorders were most commonly diagnosed as comorbid disorders, while in men substance disorders were most commonly diagnosed. Most patients were treated by individual psychotherapy. We discuss the difficulties of the "sexual addiction" concept critically and propose an algorithm to facilitate the diagnostic process. This algorithm differentiates between the paraphilic and non-paraphilic (we use the term paraphilia-related disorder) types of excessive sexual behavior first. As a second step it includes a dynamic perspective differentiating between a progressive and a non-progressive course.

We thank the members of the German Society of Sex Research (Deutsche Gesellschaft für Sexualforschung) for answering the questionnaires.

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To date, empirical research on aspects of diagnostic criteria (reliability, and validity) and response to treatment of so-called sexual addiction is growing. However, there is still a lack of clear diagnostic criteria (Coleman, Raymond, & McBean, 2003; Gold & Heffner, 1998; Goodmann, 1993, 1998). In the German-speaking countries (Germany, Austria, Switzerland) the terminology for an addictive sexual behavior has a long tradition following Richard von Krafft-Ebing's (1903) description of so-called "Hyperesthesia sexualis" showing similarities to morphinism or alcoholism. Giese (1962), a prominent German sex researcher, considered an addictive course for the diagnostic guidelines of sexual perversions (in that time synonymously used for paraphilias). The guidelines he used for his definition are similar to definitions for addiction and included a decline to pure sensuality; an increase in frequency accompanied by a decrease in satisfaction; increasing promiscuity and anonymity of contacts; the elaboration of fantasy, practice and refinement; a self description of feeling compulsively addicted; and a periodicity of an urging restlessness. Schorsch (1971), who empirically investigated addictive or progressive forms of perversions, reported them only to be relevant in a subgroup of about 20% of sexual offenders. However, the terminology of an addictive or progressive form of perversions was found to be useful for juridical decisions of criminal responsibility and is still integrated into the German penal code. On the other hand empirical studies about individuals with non-paraphilic sexual addictions in the German speaking countries are still missing.

The description of "out-of-control" sexual behavior by Carnes (1983, 1991) as an addiction was followed by an ongoing and controversial debate about this subject in the international literature. Quadland (1985) characterized this behavior as sexual compulsivity, whereas Barth and Kinder (1987) suggested the term "sexual impulsivity" and reserved the term addiction only for substance related disorders. Schwartz (1992)—noting the high rates of sexual victimization during childhood in persons who later show sexual addictive symptoms—regarded these symptoms as an aspect of posttraumatic stress disorders. According to Coleman et al. (2003), sexual compulsivity may represent a variant of obsessive-compulsive disorders. However, this study group (Raymond, Coleman, & Miner, 2003) could show that individuals with compulsive sexual behavior (N = 25) exhibited more traits of impulsivity than of compulsivity. Levine and Troiden (1988) criticized the whole concept of sexual addiction as being stigmatizing and a myth.

The *DSM-III-R* (APA, 1987) described sexual addiction under the term psychosexual disorders not otherwise specified, but this diagnosis was dropped in the *DSM-IV* (APA, 1994) and was also not integrated into the *DSM-IV-TR* (APA, 2001). In the International Classification of Diseases (ICD-10; WHO, 1993) "excessive sexual drive" (F52.8) is part of the sexual dysfunction section. However, to our knowledge investigations about cross-cultural

aspects or comparisons of ICD-10 (WHO, 1993) and DSM-IV-TR (APA, 2001) concepts of sexual addictive behaviours are missing.

Goodman (1993, 1998) proposed a set of diagnostic criteria for addictive disorders that could be applied to either behavior disorders or substance abuse. By his definition of addiction, any behavior used to produce gratification and to escape internal discomfort can become compulsive and constitute an addictive disorder. In his opinion there are two key features to distinguish sexual addiction from other patterns of sexual behavior: (a) the individual is not able to control the sexual behavior, and (b) the sexual behavior has significant harmful consequences but continues despite these outcomes. Kafka and Hennen (1999, 2002) described the concept of paraphilia-related disorders (PRDs) which they defined as "sexually arousing fantasies, urges or activities that are culturally sanctioned aspects of normative sexual arousal and activity but which increase in frequency or intensity (for more than 6 months duration) so as to preclude or significantly interfere with the capacity for reciprocal affectionate activity" (Kafka & Hennen, 1999, p. 306). PRDs include compulsive masturbation, protracted promiscuity, pornography and telephone-sex dependence, severe sexual desire incompatibility and cybersex dependence. In contrast with paraphilias, a group of sexual conditions characterized by deviant sexual arousal, PRDs were characterized as disinhibited or excessive expressions of adult heterosexual or homosexual object choice. According to Kafka and Hennen (1999, 2002) PRDs can occur as distinct disorders or in comorbidity with paraphilias. The advantage of this concept seems to be that it uses a descriptive term without characterizing the putative underlying mechanisms (such as impulsivity, compulsivity, or addiction). Another strength may be that individuals with paraphilias and PRDs share many clinical characteristics (Kafka, 2000). On the other hand patients without paraphilic symptoms may feel stigmatized by the use of "paraphilia" as part of the term PRD.

Sexual addictive symptoms in paraphilic as well as in nonparaphilic individuals can be accompanied by high rates of other psychiatric disorders (up to 40% have anxiety disorders (Kafka & Hennen, 2002; McElroy et al., 1999), 70% have mood disorders (Kafka & Hennen, 2002; Raymond, Coleman, and Miner, 2003), 30–50% have substance abuse disorders (Coleman et al., 2003; Goodman, 1993; Kafka & Hennen, 2002; McElroy et al., 1999). In an anonymous survey of 75 persons suffering from sexual addiction problems (Schneider and Schneider, 1990), 39% reported also having substance abuse problems, 32% had an eating disorder, 13% characterized themselves as compulsive spenders, and 5% as compulsive gamblers. Persons with sexual addiction may also present with complications to their physical health, such as sexually transmitted diseases or abuse of sexual performance enhancers (e.g., "poppers") (Coleman et al., 2003).

A number of uncontrolled studies indicated that antidepressant medications, particularly the serotonin reuptake inhibitors, may reduce the

frequency and the intensity of urges to engage in addictive sexual behaviours, even when the patient is not suffering from a major depression (Berner, Hill, Briken, & Kraus, 2004; Briken, Hill, & Berner, 2003; Coleman et al, 2003; Kafka, 1991; Kafka & Prentky, 1992; Stein, Hollander, & Anthony, 1992).

Treatment of sexual addiction problems should include the psychological and pharmacological treatment of comorbid disorders. It is generally agreed that, no matter what the primary addiction, if a substance use disorder is present, it should be treated first (Schneider & Irons, 2001). Early treatment of sexual addiction often starts with aspects of psychoeducation, involvement of family members or partners and helping in decisions about self-disclosure. Shame may be treated most effectively in group therapy, where other persons can provide confrontation and support. Developmental aspects like family dysfunction, traumatic experiences or neglect may be addressed well in an individual setting. Goodman (1998) presents a psychotherapeutic stage model integrating pharmacotherapeutic, behavioral and psychodynamic approaches. During Stage I (initial behavior modulation) individuals who engage in addictive sexual behavior can begin to modulate this behavior by means of a combination of inner motivation, psychological support and affect-regulating medication (SSRIs, antiandrogens in severe cases). In Stage II (stabilization of behavior and affect) relapse prevention is addressed to distinguish between forms of sexual behavior that are high-risk and those that are low-risk, and to refrain from engaging in high-risk forms of sexual behavior. In addition, patients learn to engage in sexual behavior in ways that are healthy rather than pathological. Stage III focuses on personality pathology mostly by a psychodynamic psychotherapeutic approach. Sometimes couple therapy seems to be useful, too.

The 12-Step program of Alcoholics Anonymous has been adapted in programs for sexual addiction. Programs modelled after Al-Anon (the mutual-help program for families and friends of alcoholics) are also implemented in Germany. Self-help groups appear to be most helpful during Stages I and II and in the beginning of Stage III.

Are German specialized sex therapists confronted with sexual addiction problems in their patients? Which diagnostic complications arise and how do German sexual therapists treat sexual addiction? To address these issues, we assessed current opinions about diagnoses, comorbidity and treatment in a national sample of members of the German Society for Sex Research (Deutsche Gesellschaft für Sexualforschung).

METHOD

Study Procedures

In 2004 the German Society for Sex Research had 236 members of which 149 were currently working as therapists (other members included sociologists,

jurists, unemployed or retired therapists). In July 2004, a 12-item questionnaire (see Appendix) was sent by mail to these 149 members asking them whether they had treated (during the last year) or were currently treating patients who experienced sexual addiction problems. The questionnaire had to be sent back within a two months period.

Study Sample

Of the 149 therapists, 43 (28.9%) completed and returned the questionnaire anonymously (mean age 42.9 yrs). Of the responders, 58.1% were female, 41.9% male therapists, 39.5% were working in an outpatient setting or in private practice, and 20.1% in hospitals (39.5% did not answer this question). Most of them (86.0%) were psychiatrists and/or psychological psychotherapists. There were only a few psychotherapeutically working gynaecologists (9.3%) or social workers (4.7%).

Twenty-three therapists out of the whole group (53.5%) were currently treating 50 patients with sexual addictive symptoms (22% female; 78% male). Twenty-seven of 43 therapists (62.8%) had treated 64 (21.8% female; 78.2% male) patients with sexual addiction during the last year. All together 31 out of 43 therapists reported about 97 different patients (19.6% female; 80.4% male).

Measures

Therapists were asked to specify for each of their patients under which diagnoses using ICD-10 criteria (WHO, 1993) sexually addictive symptoms were subsumed. We proposed the ICD-10 (WHO, 1993) diagnoses excessive sexual drive (F52.8), other habit and impulse disorder (F63.8), other disorder of sexual preference (F65.8), and a free section if other diagnoses were given (multiple answers were not possible for the diagnosis of "sexual addiction"). Additionally, questions addressing comorbid diagnoses (also using ICD-10 criteria) were asked proposing the sections organic mental disorders (F0), disorders due to psychoactive substance use (F1), schizophrenia, schizotypal and delusional disorders (F2), mood disorders (F3), neurotic disorders (F4), eating disorders (F50), sexual dysfunctions (F52), personality disorders (F60) and disorders of sexual preference (F65). For comorbid disorders multiple answers were possible. Finally we asked how the patients were treated.

Data Analysis

Group comparisons between female and male patients were undertaken using chi square analyses for binary data. Fisher's exact test was calculated for binary data if one cell showed an expected frequency below five. Statistical analysis was performed using SPSS 11.5.

RESULTS

Symptoms and Diagnosis of Sexual Addiction

Table 1 shows that the most common symptoms of sexual addiction were pornography dependence, compulsive masturbation and protracted promiscuity. Pornography dependence was significantly more often reported in men ($\chi^2 = 12.00$, df = 1, $p \leq .001$). In the free comment section of the questionnaire for three patients self-injurious behavior concerning the genitals was described. In the questionnaire section where therapists could give ICD-10 diagnoses to the current non-paraphilic sexual addiction the most common diagnosis was excessive sexual drive, which was reported more frequently in women than in men ($\chi^2 = 12.65$, df = 1, $p \leq .000$). Regarding (other) impulse control disorders there was no gender difference. However, the diagnosis of (other) disorders of sexual preference was only given in men (Fisher's exact test $p \leq .05$). Twenty-eight patients did not receive any specific diagnosis for their non-paraphilic sexually addictive behavior.

Specific paraphilic disorders (disorders of sexual preference according to ICD-10) were rated in less than 10% and—except sexual masochism—only in men.

Psychiatric Comorbidity

Neurotic disorders (e.g., anxiety disorders) were the most frequent comorbid diagnostic category, mainly given for the female sample ($\chi^2 = 14.49$, df = 1, $p \leq .000$). More than a third of the women suffered also from eating disorders (Fisher's exact test $p \leq .000$). In men disorders due to psychoactive substance use were common (Fisher's exact test $p \leq .05$). There was also a trend towards more sexual dysfunctions in men (Fisher's exact test $p =$ 067). Diagnoses of personality disorders (PDs) were generally rare except borderline and avoidant PDs in women.

Treatment

Almost 90% of the 31 therapists that had treated or were currently treating patients with sexual addiction problems used psychotherapy, mainly in an individual setting and more often with psychodynamic than cognitive-behavioral techniques. Only two therapists were working with patients in groups, but we have no information whether this was specialized for sexual addictive patients. Twenty-five percent of the therapists also used medication (mainly antidepressant agents, in two cases antihormonal medication) for treatment. Only two therapists recommended self-help groups or an inpatient treatment to their patients.

Thirty-six of 43 answering therapists (83.7%) do not (in general) think that "sexual addiction" is a distinct disorder.

TABLE 1 Symptoms and Diagnoses of Sexual Addiction according to the ICD-10 Classification in 97 patients

	Total Sample		Female Sample		Male Sample	
Variable	N = 97	%	N = 19	%	N = 78	%
Symptoms of Sexual Addiction (multiple answers possible)						
Pornography Dependence[a]	39	40.2	1	5.3	38	48.7
Compulsive Masturbation	30	30.9	3	15.8	27	34.6
Telephone-sex Dependence	9	9.3	0	0	9	11.5
Cybersex Dependence [a]	2	2.1	2	10.5	0	0
Protracted Promiscuity	23	23.7	7	36.8	16	20.5
Self-injurious Behavior	3	3.1	2	10.5	1	1.3
Diagnoses (ICD-10) for the Sexual Addictive Behaviour (multiple answers *not* possible)						
Excessive Sexual Drive (F52.8)[a]	37	38.1	14	73.7	23	29.5
Other Impulse Control Disorder (F63.8)	16	16.5	3	15.8	13	16.7
Other Disorder of Sexual Preference (F65.8)[a]	16	16.5	0	0	16	20.5
None of These Diagnoses [a]	28	28.9	2	10.5	26	33.3
Specific Disorders of Sexual Preference (multiple answers possible)						
Sexual Sadism	7	7.2	0	0	7	9.0
Sexual Masochism	6	6.2	3	15.8	3	3.8
Pedophilia	7	7.2	0	0	7	9.0
Exhibitionism	6	6.2	0	0	6	7.7
Voyeurism	4	4.1	0	0	4	5.1
Fetishism	2	2.1	0	0	2	2.6

Note. [a]Statistically significant differences between the female and the male sample according to the χ^2 analyses for binary data or to Fisher's exact test.

DISCUSSION

A majority of the answering members of the German Society for Sex Research reported that they had treated patients with sexual addiction problems. This finding should be interpreted with caution because of the limitations of the survey. The response rate of 28% was very low and there is a serious risk of a selection bias. This may be due to the fact that therapists who did not have experience with such patients simply did not return the questionnaire. No standardized and symptom-based instruments were used to assess the primary diagnosis and the comorbid sexual and other mental disorders. In spite of these limitations this is the first published survey on this subject in Germany and some interesting findings have to be mentioned although the small sample size limits its generalizability.

The gender distribution showed similarities to previous research studies in the literature (Coleman et al., 2003; Goodman, 1998) reporting more pornography dependence in men while protracted promiscuity was more

TABLE 2 Comorbid Diagnoses (ICD-10) in 97 Patients

	Total Sample		Female Sample		Male Sample	
Variable* (multiple answers possible)	N = 97	%	N = 19	%	N = 78	%
Organic Disorders (ICD-10: F0)	1	1.0	0	0	1	1.3
Disorders Due to Psychoactive Substance Use (ICD-10: F1)[a]	15	15.5	0	0	15	19.2
Schizophrenia, Schizotypal and Delusional Disorders (ICD-10: F2)	1	1.0	0	0	1	1.3
Mood Disorders (ICD-10: F3)	16	16.5	3	15.8	13	16.7
Neurotic Disorders (ICD-10: F4)[a]	35	36.1	14	73.7	21	26.9
Eating Disorders (ICD-10: F50)[a]	7	7.2	7	36.8	0	0
Sexual Dysfunctions (ICD-10: F52)	19	19.6	1	5.3	18	23.1
Personality Disorders (ICD-10: F6) (multiple answers possible)						
Schizoid	2	2.1	0	0	2	2.6
Dissocial	1	1.0	0	0	1	1.3
Borderline	7	7.2	3	15.8	4	5.1
Anancastic	4	4.1	0	0	4	5.1
Avoidant	13	13.4	5	26.3	8	10.3
Narcicisstic	3	3.1	0	0	3	3.8

Note. *Due to the small sample size diagnoses are given in ICD-10 F-categories.
[a]Statistically significant differences between the female and the male sample according to the χ^2 analyses for binary data or to Fisher's exact test.

common in women with sexual addiction problems. Comorbid diagnoses in the patients varied (neurotic disorders and eating disorders were more common in women, substance abuse and sexual dysfunctions in men) and showed the whole range of comorbidity reported in the literature.

Even among therapists who are specialized in treating sexual problems there seems to be little consensus how to diagnose (non-paraphilic) sexual addictions. Most of the German therapists (83.7%) do not regard sexual addiction as a distinct disorder and may generally tend to subsume such symptoms under other psychiatric disorders. This finding indicates some dilemmas. An

TABLE 3 Treatment of Sexual Addictive Behaviors

Treatment form	Therapists N = 31	%
Psychotherapy (multiple answers possible)	27	87.1
Cognitive-Behavioral	9	29.0
Psychodynamic	18	58.1
Individual Setting	26	83.9
Group Setting	2	6.5
Partner Setting	2	6.5
Medication (multiple answers possible)	8	25.8
Antidepressant Agents (i.e., SSRI)	6	19.4
Antihormonal Agents	2	6.5
Recommendation of Self-help Groups	2	6.5
Recommendation of Inpatient Treatment	2	6.5

addictive course in a specific disorder of sexual preference (DSM-IV-TR: paraphilia) like sadism or pedophilia may be seen as a sign of severity rather than a distinct comorbid disorder (Berner et al., 2004). On the other hand there are patients suffering from non-paraphilic sexual excessive symptoms (without paraphilic symptoms) that may appear as more addictive, impulsive, or compulsive. Leaving aside how one may label the problem, patients report that they are not able to control the sexual behavior, and suffer from harmful consequences and continue despite this. One may argue that diagnosis could be given due to the most "evidence based" therapeutic approach, in fact, to date in sexual addiction there is none, although many concepts seem to work. This may be reflected by the diversity of therapeutic approaches reported in our survey.

Our results together with other reports in the field underline the problem of lacking clear diagnostic criteria for non-paraphilic sexual addiction symptoms. We would like to propose a diagnostic algorithm that differentiates between the paraphilic and non-paraphilic types of excessive sexual behavior. This clear division seems to be important for clinical, forensic psychiatric as well as for research purposes.

Diagnosis starts with the criterion of a recurrent failure to control sexually arousing fantasies, sexual urges, or behaviors over a period of at least 6 months. These sexual fantasies, urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The disturbance is not better accounted for by another mental disorder (e.g., manic episode) and is not due to a general medical condition. The main distinction between the two types is that the paraphilic one involves unconventional sexual behaviors and the non-paraphilic type involves conventional or at least not deviant sexual behaviors. Within each type several subtypes exist.

According to Kafka and Hennen (1999, 2002) we use the term "paraphilia related disorder" for the non-paraphilic type. In our opinion the ICD-10 term "excessive sexual drive" does not reflect research results that engagement in non-paraphilic sexually excessive behavior may be less due to increased desire but more to use sex as a mechanism to cope with personal distress, e.g., mood disorders (Bancroft et al. 2003; Bancroft, Janssen, Strong, & Vukadinovic, 2003). Comorbidity between the paraphilic and the non-paraphilic type should only be diagnosed if non-paraphilic symptoms occur independently from paraphilic ones and are not a sign of paraphilic progression. Many researchers and clinicians agree that there is a possible progression of symptomatology in sexual addiction problems (Berner et al., 2004; Giese, 1962; Schorsch, 1971). If a paraphilic behavior, for example, is accompanied by an increase in masturbation frequency with paraphilic fantasies or behaviors and a decrease in satisfaction, excessive masturbation should not be diagnosed as a distinct disorder but could be viewed as a symptom of progression. The division between progressive and non-progressive

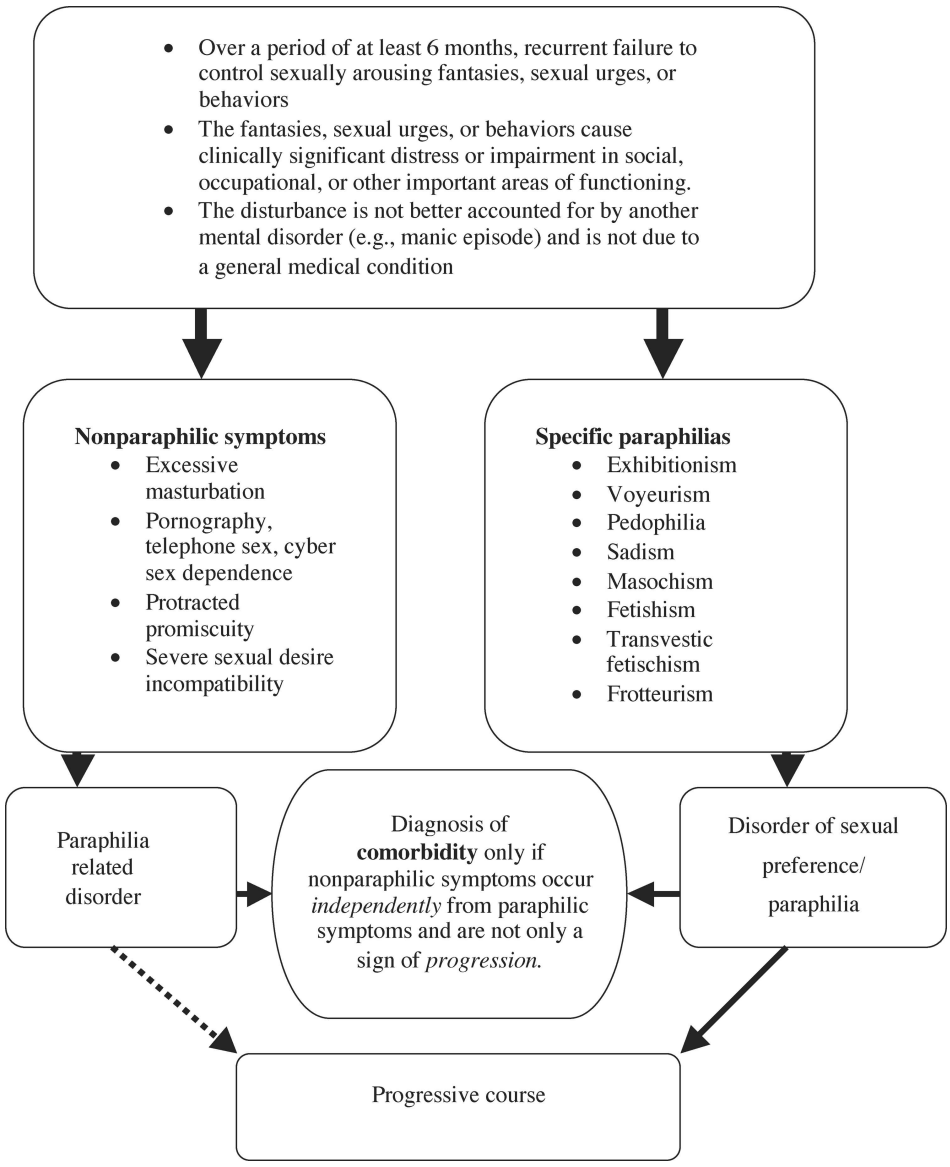

FIGURE 1. Diagnostic algorithm for nonparaphilic and paraphilic sexual excessive symptoms.

forms of the paraphilia related disorders might be less clear due to the fact that the diagnostic threshold of the latter is more quantitative. However, increased frequency and decreased satisfaction as well as the above mentioned significant distress or impairment in social, occupational, or other important areas of functioning help to make a distinction.

Even among specialized German sex therapists there seems to be little consensus on how to diagnose sexual addiction problems. Further research

is needed to investigate whether the proposed diagnostic algorithm facilitates the diagnostic process, especially for the non-paraphilic subtype.

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APPENDIX

Sample of a translated version of the questionnaire

Questions concerning the therapist:

1. Age?
2. Gender?
3. Profession?
4. Working in an outpatient/inpatient setting?

Questions concerning the sexually addicted patients or sexual addiction in general:

5. How many patients with sexual addiction problems do you treat at the moment (number of females and males)?
6. How many patients with sexual addiction problems have you treated during the last year (number of females and males)?
7. How did you treat these patients (medication, psychotherapy, self-help group etc.)?
8. Do you think (in general) that sexual addiction is a distinct disorder (yes, no, unclear)?
9. Do you think the current therapeutic system for sexually addicted patients in Germany is sufficient (yes, no, unclear)? (*Results were not reported here)*

Questions concerning each treated sexual addicted patient:

10. What symptoms did the patient show?
11. Which ICD-10 diagnosis did you give for the sexual addiction problem?
12. Which comorbid disorders did you diagnose due to ICD-10 criteria?