A Response to Aviel Goodman's "Sexual Addiction: Designation and Treatment"*

CHARLES MOSER

Dr. Goodman's recent article* concerning the concept of sexual addiction was very interesting, but brings up several points I would like to discuss. He correctly reports that there is agreement that the behavior exists but there is still controversy as to how to designate it. He unfortunately glosses over the controversy concerning whether the behavior is secondary to other diagnoses or comprises a separate diagnostic category. Additionally, how a therapist would distinguish the nonpathologic presentations of the behavior from the pathologic is not well documented. These are not trivial points to his thesis.

To accomplish his goal of creating the diagnostic label "sexual addiction" he first must create the diagnostic label "addiction." While the term "addiction" is commonly and extensively used by both professionals and lay persons, the term does not exist in DSM-III-R[2]. The manual does recognize psychoactive substance dependence of several licit and illicit substances, but the word "addiction" is clearly and purposely absent. The manual does allow for pathological gambling, under the heading of "Impulse control disorders not elsewhere classified," clearly avoiding the addiction concept again. Further, DSM-III-R does not recognize a diagnostic category that would be equivalent to a food addiction.

While the development of the theory of addiction and a discipline of addictionology is currently ongoing, this part of Goodman's paper appears to be misplaced. Proposals for instituting or changing the diagnostic criteria for addiction should appear in the psychiatric or addiction literature, so that the criticism of this proposal can be debated by experts in those fields. A review of the criticisms of the term "addiction" is beyond the scope of the present essay. Nevertheless, if the concept of addiction continues to be rejected, Goodman's thesis must also be rejected by similar reasoning.

Goodman's criteria for the diagnosis of sexual addiction are germane to the readers of the *Journal of Sex & Marital Therapy*. For a new diagnostic

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Charles Moser, Ph.D., M.D., is Professor of Sexology, Institute for Advanced Study of Human Sexuality, 1523 Franklin Street, San Francisco, CA 94109, and is at the Department of Medical Education, St. Mary's Hospital and Medical Center, 450 Stanyan Street, San Francisco, CA 94117.

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category to have meaning, it must first be shown that there are individuals that properly belong to that category and that they are not a subset of another already accepted diagnostic category. It must also be shown that the behavior is the source of the problem rather than a manifestation of another psychiatric diagnosis. Unfortunately, neither point is made. In fact, despite a good review of the literature, the basic question of whether the behavior described constitutes or warrants the creation of a new diagnostic category (i.e., sexual addiction) has not been answered in a compelling way.

Despite this inadequacy, we can still view the diagnostic criteria critically. It can be argued that if only one situation can be presented that fits the diagnostic criteria, but not the diagnosis, then the criteria are fatally flawed. The example to be considered is marital coitus. Considering the first three and the last criteria Goodman presents (Goodman's criteria are reproduced in the Appendix), one can see that: A. There can be a recurrent failure to resist impulses to engage in marital coitus. B. Many experience a sense of tension prior to the behavior. C. Many experience pleasure or relief while engaging in the behavior. E. Sexual interest in one's spouse hopefully lasts more than a month. In fact, it would seem that these are useful criteria to judge healthy sexual relationships.

To qualify for the diagnosis, one only needs to satisfy 5 of 9 additional criteria, listed under D. These five are, item numbers 1, 2, 4, 6 and 9: A sign of a good marital sexual relationship is frequent preoccupation with sex or activities preparatory to sex. When the sex is good, we tend to indulge in it to a greater extent or over a longer period of time than intended. Most of us spend a great deal of time (whatever a great deal is) engaging in sex, because it is important and pleasurable to us. As a marital therapist I know that healthy marriages must give up or reduce social, occupational, or recreational activities to create the time and atmosphere for good sex. And failure to engage in marital coitus can lead to restlessness or irritability. Thus, a healthy marriage can be construed as consisting of sexual addicts.

While it can be argued that this was not the way Goodman intended his diagnostic criteria to be interpreted, this does not change the result. The issue is not to devise better and more stringent criteria, though that will be needed if Goodman and others wish to pursue his thesis. Rather, that the concept and its interpretation are not sufficiently clear at this point in time to justify a new diagnostic label.

While Goodman suggests that the concept of sexual addiction is devoid of bias against any specific sexual behavior, this has not been my experience. Societal norms influence psychiatric diagnoses and psychotherapy styles in all cultures, and some have been used as a tool to ensure adherence to political dogma (as in the USSR). Since, as already shown, marital coitus can be misinterpreted under the diagnostic criteria as a sexual addiction, it is easy to see how more unusual and societally disapproved behaviors can be so labeled. There is a long history in psychiatry of blaming mental illness on the practice of various sexual behaviors, masturbation and homosexuality to name the two most obvious historical

examples. As scientists we should avoid these value judgments at all costs; as therapists we should recognize the power and ramifications of our pronouncements.

Sexual addiction is one of the diagnostic labels that patients often give themselves. By itself that is not a problem. But when the individual chooses a therapist to support the label, this can lead to other diagnoses being missed or ignored. In my clinical practice, patients often contend that they are sexual addicts. I rarely concur with their diagnosis, but usually find significant depression, paraphilias, and conflict with societal expectations, among other problems. Goodman also must find similar concurrent problems, considering the wide range of drug and psychotherapeutic interventions that he finds necessary to treat sexual addiction.

Throughout the country, there are numerous treatment programs, therapists, and self-help groups that purport to diagnose and treat sexual addicts. Essentially nothing is known about the long-term efficacy and complication rates of these programs. Potential abuse is acknowledged by Goodman and should not be so easily dismissed. Many people spend significant amounts of time and money for the treatment of their purported sexual addiction. Without long-term follow-up that shows success, these programs should be labeled experimental and informed consent obtained before entry.

If a diagnostic category is added to or deleted from an edition of the DSM, that decision has important and widespread ramifications. The process has clear political and societal agendas. The result has very clear monetary consequences. To add a category allows therapists/psychiatrists to collect fees from insurance companies for, and legitimizes the treatment of, the "new" disorder. Without proof of efficacy or need, the psychiatric establishment would be legitimizing this therapeutic approach.

Psychiatry chose to depathologize homosexuality partly due to the inability of research to demonstrate any connection between the sexual orientation of the patient and the psychiatric problems they were exhibiting. There was no indication that homosexuals had stopped seeking help from psychiatrists to stem the psychic pain and avoid societal penalties related to their sexual behavior. What it did say was that the focus of therapy should not be changing the patient's sexual orientation, since the methods to do so were ineffective and the theory that their problems were due to their sexual orientation was false. It would seem that the same argument could be used at this time concerning sexual addiction. The therapy has not been shown to have any long-term success, nor can the problems they experience be related to the offending sexual behavior. The second point becomes apparent when considering the number of sexual addicts that are coincidentally addicted to other substances or behavior patterns. Whether there is an addictive personality disorder is best left to the addictionologists.

There is no doubt that there are people in pain due to their inability to control their sexual behavior. How a therapist conceptualizes that problem is the issue before us. Goodman has made an honest attempt to

suggest that the concept of sexual addiction may be of help to both the therapist and patient/client/addict. Unfortunately, sexologists (and especially clinical sexologists) still await research that proves or disproves the existence of the new entity presumptively called "sexual addiction." Before the concept of sexual addiction is accepted, treatment success and failure data must be presented. Attempts at creation of diagnostic criteria should consistently distinguish addictive and nonaddictive sexual behaviors, and do so in a societally neutral manner. Unfortunately, we must conclude that Goodman has not succeeded in his attempt to accomplish this feat.

APPENDIX

Sexual Addiction

A. Recurrent failure to resist impulses to engage in a specified sexual behavior.
B. Increasing sense of tension immediately prior to initiating the sexual behavior.
C. Pleasure or relief at the time of engaging in the sexual behavior.
D. At least five of the following:
   1) frequent preoccupation with the sexual behavior or with activity that is preparatory to the sexual behavior
   2) frequent engaging in the sexual behavior to a greater extent or over a longer period than intended
   3) repeated efforts to reduce, control, or stop the sexual behavior
   4) a great deal of time spent in activities necessary for the sexual behavior, engaging in the sexual behavior, or recovering from its effects
   5) frequent engaging in the sexual behavior when expected to fulfill occupational, academic, domestic, or social obligations
   6) important social, occupational, or recreational activities given up or reduced because of the sexual behavior
   7) continuation of the sexual behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the sexual behavior
   8) tolerance: need to increase the intensity or frequency of the sexual behavior in order to achieve the desired effect, or diminished effect with continued sexual behavior of the same intensity
   9) restlessness or irritability if unable to engage in the sexual behavior.
E. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.[1] (pp. 306–307)

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1. Goodman, A: Sexual addiction: Designation and treatment. *J Sex Marital Ther 18* (4):303–314, 1992.
2. American Psychiatric Association: *Diagnostic and statistical manual of mental disorders* (3rd ed, rev). Washington, DC, APA, 1987.