Journal of Substance Use, August 2005; 10(4): 253–259

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CASE REPORT

Diagnostic and psychodynamic aspects of sexual addiction appearing as a non-paraphiliac form of compulsive sexual behaviour

JÓZSEF GEREVICH[1,2], TAMÁS TREUER[2], ZOLTÁN DANICS, & JUDIT HERR

[1]*Addiction Research Institute, Budapest, Hungary, and* [2]*Department of Psychiatry, Addiction Medicine and Child Psychiatry, Semmelweis Medical University*

Abstract
Background: In recent decades, the diagnosis of sexual or love addiction has increasingly become part of the spectrum of addiction medicine. Although it does not figure under this name in either the BNO-10 or DSM-IV, the present scientific position is that it can be regarded as a compulsive sexual behaviour disorder that does not show the criteria of paraphilia.
Method: A case report.
Results: In the case of the 61-year-old patient we observed, the problems of an extramarital relationship play a central part in the syndrome with a serious conflict situation and prolonged personal and family crisis. This sexual addiction can be interpreted as identification with the father and also as the means of masculine identity. The sexual behaviour meets the criteria of addiction. Follow-up will decide the stability of the diagnosis. In connection with this case, the authors attempt a psychodynamic analysis of triangular relationships destabilizing couple relationships.

Keywords: *Sexual addiction, behavioural addiction, compulsive sexual behaviour, paraphilia.*

> If you are vulnerable, you are not loved or have no security, sex can become addictive in your life like cocaine. (Jeanette Batz)

Clinical specialists engaged in therapy have long been interested in compulsive sexual behaviour. In recent decades, a great many books and relatively few articles, especially in the elite journals, have been published on the question. In Hungary, Kelemen (1994) pointed out the significance of the syndrome, placing the emphasis mainly on its cultural historical aspects.

The syndrome was first described as ''love and hate addiction'' in delinquent male adolescents (Hoppe, Molnar, & Newell, 1965). Later, the terms ''love'' and ''sexual'' were used as alternatives to name the syndrome, or the two expressions were used

Correspondence: József Gerevich, Budapest, Pf. 216, 1276 Hungary. E-mail: gerevichj@axelero.hu

ISSN 1465-9891 print/ISSN 1475-9942 online
DOI: 10.1080/14659890412331318930

together (Simon, 1982; Timmreck, 1990; Young, 1990). However, it became widely known as sexual addiction. The concept has since been greatly expanded in popular science literature and the mass media. It has been used to characterize serial murderers (Dobson) and even Bill Clinton's relationship with Monica Lewinsky (Levin, 1998).

Diagnostic criteria

It was mainly through the work of Carnes that the syndrome became known. Carnes (1983) classifies compulsive sexual behaviour in the spectrum of addiction medicine, since the disorder meets the criteria of addiction in all respects: compulsive behaviour; tolerance (increase in the number of sexual activities); appearance of withdrawal symptoms if the behaviour is prevented; increase in the quantity of time spent on the behaviour to the detriment of other important activities; breakdown of important relationships, decline in work activity as a result of the compulsive behaviour. Carnes describes the following variants of sexual addiction:

- compulsive masturbation, accompanied by sexual fantasies, viewing pornographic pictures on television, video, the Internet;
- compulsive sexual behaviour with prostitutes;
- anonymous sexual behaviour with a number of partners;
- frequent visits to topless bars, model studios, book and video film distributors;
- habitual exhibitionism;
- habitual voyeurism;
- tendency to inadequate sexual contacts;
- recurring sexual abuse of children;
- tendency to rape.

In the common spectrum of addictions interpreted in the wider sense, sexual addiction belongs among the behavioural addictions (Bissette, 2004; Marks, 1990).

Schwartz (1998) distinguishes two kinds of sexual addiction. One is when sexual life causes such disturbance that the only form of solution is to intensify sexual activity. In the other case, compulsive sexual behaviour arises related to the opening in the centre of the mouth and the urge to close this opening.

Diagnostic systems and sexual addiction

It is an interesting fact that sexual addiction does not figure in any of the major diagnostic systems. According to the definition of the Society for the Scientific Study of Sexuality (1999), paraphiliac and non-paraphiliac forms of compulsive sexual behaviour can be distinguished. The paraphilias found in both the BNO-10 and the DSM-IV diagnostic systems are the following: paedophilia, exhibitionism, voyeurism, sexual masochism, sexual sadism, transvestite fetishism and frotteurism. According to the DSM-IV definition, the paraphilias are recurring, intensive and sexually exciting fantasies, sexual urges or forms of behaviour which (1) are not directed at human objects, (2) involve the humiliation of the patient or his/her partner, or (3) involve children or other vulnerable persons not participating in the communication on an equal footing. The behaviour, sexual urges or fantasies cause clinically substantial stress in social or workplace situations, or other important areas of life (American Psychiatric Association, 1994). Because of its consensual nature, sado-masochism does not belong among the paraphilias.

The concept of non-paraphiliac compulsive sexual behaviour applies to forms of sexual behaviour differing essentially from the average, of a recurring nature, causing distress and disrupting the previously accustomed way of life. In DSM-IV, the category of ''not otherwise specified sexual disorders'' corresponds to this concept. In BNO-10, the syndrome can be related to ''disorder of sexual relationship'' (F66.2), to ''unspecified psychosexual development disorder'' (F66.9) or to ''unspecified disorder of sexual preference'' (F65.9).

No case corresponding to sexual addiction or to non-paraphiliac compulsive sexual behaviour has ever been published in Hungary.

Case description

Cs. L., a 61-year-old man was taken into outpatient treatment in April 2000 at his own request, under the strong influence of his wife. The case history includes a gradual reduction of hearing on the left side 5 years ago. A brain CT done at that time did not exclude the possibility of an acusticus neurinoma on the left side.

His current problem is that he has been living for years in a situation of conflict, which is a cause of great frustration for him and the members of his immediate family—his wife, mother and two daughters. The conflict can be traced back to an extramarital relationship that began 6 years ago. At that time, he formed a sexual relationship with a 42-year-old childless woman, who was at first living with a partner and later alone. The relationship consisted of increasingly frequent and longer sexual relations. Three years ago his daughters revealed the affair to his wife when they pointed out to her that the other woman was spending too much time in the shop her husband operated. In answer to a straightforward question asked by the wife about the relationship, Cs. L. gave a straightforward answer. After that, an increasingly serious conflict arose between Cs. L. and his wife, who found it increasingly difficult to tolerate the situation. He tried several times to break off the relationship with his lover, but on the third day of sexual ''withdrawal'' he experienced such serious tension, irritability, nervousness, sleep disorder and inability to work that he had to end the ''abstinence'' begun voluntarily, and he returned to the woman. According to his account, he does not have strong emotional ties to the woman and they have little in common. It is mainly the sexual relationship that keeps them together. He calls his partner—who is able to tie him to herself sexually in a ''expert'' way, with her sexual openness, lack of inhibitions and the ''suppleness'' of her skin, characteristic of childless women—''Barbie Doll''.

His psychosexual development is characterized by the early awakening of heterosexual interest. Already at the age of 5–6 years he played games of the ''what have I got, what have you got'' type. He lost his ''virginity'' at the age of 19 years. He generally had long heterosexual relationships lasting many years. He met his wife 30 years ago. A strong emotional bond sustains their marriage; he describes his wife as an attractive, serious, mature woman who is perfectly suited as a wife but ''can't give me what I need in bed''. As a result he has had a number of long-term extramarital sexual relationships. They were all discovered because, as he admits, he is unable to keep a secret. His previous sexual relationships did not evoke the same strong dependence in him.

The course of his present marriage resembles his parents' marriage. His father also had a number of extramarital relationships. When one of them was discovered, his mother broke off sexual relations with him but continued to fulfil her duties as a wife.

In recent years Cs. L. ''has become a shadow of himself''. His friends, too, say that he has changed greatly, is absent-minded, unable to concentrate and interested only in ''sex''. He cannot recall elementary things.

No internal medicine or neurological abnormality could be found; from the psychiatric viewpoint his consciousness is clear, his orientations are unimpaired and no psychotic symptom or sign of dementia could be observed. He performs well on simple tests of attention and memory. In the California Personality Inventory he is characterized by very low self-esteem, self-strength, sense of responsibility, leadership abilities and demand for dominance, and by a femininity level on the border of masculinity-femininity.

Discussion

Diagnostic considerations

A serious diagnostic dilemma arises in this case over whether his present sufferings are related to some kind of disease at all, or whether they must be regarded as a crisis attributable to a prolonged, unsolved conflict and inability to make a decision. The circumstance that feelings of distress related to the sexual bond and tensions related to the marital and even family conflict are inextricably intertwined makes it difficult to decide this question. The crisis diagnosis is reinforced by a remark made by the patient: ''If my wife would tolerate the situation, I would have no problems.'' At the same time, during the ''period of abstinence'', lasting 5 days, observed in the first month of outpatient treatment, he showed such intensive sexual desire reaching the level of craving, irritability, the restriction of attention solely to sexual longing that the state cannot be explained solely by the ''forbidden fruit effect'' and cannot be regarded as a phenomenon arising from the conflict with his wife.

In addition to the ''withdrawal symptoms'', the development of ''tolerance'' also confirms the diagnosis of behavioural addiction. Tolerance is manifested in the steady increase in the frequency of sexual encounters, while, on the emotional and intellectual level, the relationship did not develop. Another factor pointing to this is that when the patient was asked whether he would leave his wife and live with his woman friend, he gave a firmly negative answer. The shrinking of the life space to sexuality also belongs in the spectrum of addictive behaviour.

From the viewpoint of differential diagnostics, the diagnosis of dementia also arises. However, this is not supported by the data of the dementia test.

Consequently, the case can be regarded as a special manifestation of sexual addiction characterized by compulsive sexual behaviour, with strong and insuperable craving and distress, with rapid relapse.

Certain forms of behaviour that come into conflict with values may be problematic but cannot be regarded as obsessive or compulsive. The sexual behaviour of some people integrates coping mechanisms, and in this sense the heightened sex(uality) can be regarded as a kind of self-medication. Such elements can be found in our case too: the over-emphasis of the sexual relationship appears as a way of facing the phenomena of ageing. At the same time, it also plays a role in strengthening identification with the father—i.e. a kind of masculine identity.

In the literature, compulsive sexual behaviour is most often associated with promiscuity, characterized by a kind of double life: one life is lived in public with socially accepted family relations; the other, secret life is full of confused, superficial, serial, but often

simultaneous multiplex, anonymous sexual relationships (Carnes, 1983; Bissette, 2004; Society for the Scientific Study of Sexuality, 1999).

In this case, we are dealing with a relatively rarer form of sexual addiction. The patient is tied intensively, in an addictive and vulnerable way, to a single sexual partner. In the meantime, his most important human relations with his wife, his mother and his daughters are breaking up. His performance in manual work is steadily deteriorating and his way of life becoming more restricted. His behaviour gives the outside world the impression of serious mental illness.

Experts will no doubt be divided over the classification of the case among the behavioural addictions. Similar cases are often evaluated as impulse-control disorder, mood disorder, obsessive-compulsive disorder or psychosexual development disorder (Society for the Scientific Study of Sexuality, 1999). Presumably, in concrete cases of sexual disorders, interrupted sexual development or difficulties in influencing self-control or possibly compulsiveness are predominant among the symptoms and determine the diagnosis. However, in the case of our patient almost the full list of criteria of addiction could be observed, leading us to make the diagnosis of sexual addiction. We have not yet had the opportunity to make a longitudinal analysis of the case: the longitudinal course of the symptoms will decide how stable the present diagnosis proves to be.

Psychodynamic considerations

Although the case described above illustrates many of the widely held prejudices concerning the sexual behaviour of men (men are not capable of finding their spiritual and sexual partner in one woman; sooner or later they cheat on their wives with a younger ''Barbie doll''; they need polygamous sexuality free of commitment, etc.), it also throws light on the psychodynamic background to the development of such situations.

Freud declared that there are not just two partners in the bed but at least four: the object of Oedipal love is there as a ghost between the partners, even if only symbolically. Kernberg (1994) imagines the erotic battlefield to be even more populous. In his opinion, potentially six people are sleeping together in fantasy: the couple, their unconscious Oedipal rivals and the unconscious Oedipal ideals. Moreover, men also want a woman in multiple roles—as mother, as a young girl, as a twin sister and, above all, as adult woman and lover. Through the inevitable, asymmetric replacement of the primary love object, women want the man in both father role and mother role, and also as a young boy, as twin brother and adult man and lover. Men and women with a mature love life attempt to integrate these object parts and role parts in one partner with the final goal of overcoming the borderlines between the sexes, which represent a constrained limitation for narcissistic satisfaction experienced in sexual intimacy (Kernberg, 1991). Both partners long for a perfect merging with the love-object, with Oedipal and pre-Oedipal implications, which can never be fulfilled.

A certain difference can be observed in everyday practice between women and men in psychosexual development and the integration of sexuality and love. In long-term couple relationships and marriage women generally learn to desire the man they love, while men rather learn to love the woman they desire. Countless romantic pop songs and folk songs record the tragic-romantic consequences of this asymmetry which are also confirmed by therapeutic practice. The principal cause of the difference could be that, while in the case of men the primary libidinal object and the Oedipal libidinal object are the same person (the mother), in the case of women these are two different persons (the primary libidinal

object is the mother and the Oedipal libidinal object the father). It follows from this that, if a disorder arises in the early love-relationship with the mother, women are to a certain extent less vulnerable since their Oedipal ideal is another person. This appears later in their long-term partner relationships in their wish to satisfy both role expectations in one person: they expect their male partners to have both father and mother roles. By contrast, in the case of men the problem is greater since, if their mother is a rigid, unloving person in the course of their early development, in the Oedipal phase this causes at least ambivalence that she will be the Oedipal desired object. As a result, they are forced to make a kind of split with the consequence that in their partner relationships in adult life they often try to fulfil their erotic desires in different persons.

A highly important step in the development of an individual's mature, love-erotic life is when they advance from the formal, skin erotic to the substantive, core-erotic (Kernberg, 1976). This means that they progress from masturbation fantasies and later real intersexual physical stimuli and fantasies evoking erotic excitement, to love of the erotically desired person and the ability to develop empathy, solidarity and twin feelings with that person. The general indication of this state of maturity is if the person at first becomes spiritually and intellectually close to someone and then sexual desires arise independently of whether interest had first been aroused merely in the physical being of the other or not. In the case of women, it is the practical and therapeutic experience that there are generally fewer problems in this process because of the differences outlined above.

Triangulations are dangerous solutions to the unsolved Oedipal problems of both partners. In fortunate cases these can bring transitional stability to the relationship. In long-term couple relationships the tensions and demands arising from Oedipal conflicts often produce an unconscious collusion between the partners, representing a tacit agreement to find in reality a third person who embodies the ideal for one partner and the rival for the other. In the case of the unfaithful husband, this scenario often means that the third person entering the relationship is primarily a person providing sexual satisfaction, while the wife continues to be a largely intellectual partner. This is actually a primitive, not intrapsychic, interpersonal attempt on the part of men to overcome the Oedipal taboo. In this way, they simply split in two in reality as well the ambivalences towards the love-object that are difficult to tolerate over the long term. Since demands for other relations outside sexuality sooner or later appear in long-term relationships, it very often happens that men develop a strongly sexual-erotic relationship with their lovers and strive not to exceed those frames (e.g. they meet for short periods, spend most of the time together in sexual acts in which great emphasis is placed on uninhibited elements, etc.). This triangulation is often upset when the woman in the role of lover begins to make demands for a different relationship, or the wife becomes tired of the unconscious (or even overt) Oedipal-rival game and threatens to seek a divorce. Since the capacity for jealousy assumes a kind of readiness to tolerate the Oedipal rivalry as well, triangulations arise more easily if a serious narcissistic disorder in one of the partners prevents the capacity for normal jealousy. Differences in the values held by partners can lead to highly varied triangulations, which can be manifested spectacularly using sociodramatic techniques.

The long-term existence of triangulations acquires an addictive character as regards sexuality when the sharp separation of the two partner relationship spaces offers the person the possibility of creating a pseudo-identity. This means that personality traits that are otherwise further removed from the age and physical activity can be kept alive in a relationship of a specifically sexual nature, reminding the person of happy days he never

actually had in his past youth. In the same way, we find an effect of stimulus-seeking behaviour evoking the ''other state'' characteristic of impulse-control disorders, which can also be observed in the case of pathological gambling and in drug addicts. It is not by chance that persons who are actively engaged in sport in a stage of their life, but are later forced to give up this way of life involving cycloid stress because of injury or ageing, are later at great risk of developing addictive behaviours or impulse-control disorders.

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