Original Articles

Assessment and Diagnosis of Sexual Addiction

Carol Coleman-Kennedy, RN, CS, PMH-NP, MSN, and
Amanda Pendley, RN, CS, PMH-NP, MSN

As many as 20 million people in the United States are affected by sexual addiction. However, few clinicians assess for its existence, and most nursing program curricula are not addressing this phenomenon. Sexual addiction often coexists with substance addiction, and both can be destructive to persons and families. Clinicians who recognize the risk factors for possible sexual addiction, often revealed in the initial psychiatric assessment, can further assess for its existence in patients. The authors present an algorithm to enhance clinicians' abilities to recognize, assess, and diagnose sexual addiction during a substance addiction assessment.(J Am Psychiatr Nurses Assoc [2002]. 8, 143-51.)

Millions of Americans experience some form of sexual addiction (Schneider, 1991). It is a devastating disease that destroys marriages and family relationships. It puts people at risk for HIV and other sexually transmitted diseases. This addiction results in social and occupational related problems resulting from neglect of responsibilities while in pursuit of the sexual behavior (Schneider, 1991). Because sexual addiction often coexists with substance addiction (Carnes, 1991; Schneider, 1991), clinicians need to learn the risk factors and indicators that point to sexual addiction and look for these markers during the initial psychiatric assessment of patients with substance addiction. The initial psychiatric assessment can be the most important step in recognizing problematic sexual behavior. This article will describe diagnostic criteria that have been proposed for sexual addiction and suggest a plan for assessing and diagnosing sexual addiction that may coexist with substance addiction. Although clinical recognition of sexual addiction is a critical first step in accessing treatment for clients with this serious disorder, therapeutic management of sexual addiction is beyond the scope of this article.

The concept of sexual addiction was introduced in the mid-1970s. A member of a Boston Alcoholics Anonymous group identified his out-of-control sexual behavior as sexual addiction and paralleled it to his alcohol addiction (Levine & Troiden, 1988). Sexual addiction is a progressive and chronic addictive illness characterized by patterns of compulsive sexual behavior that occurs in response to internal pain and anger despite adverse consequences (Manley, 1995).

Sexual addiction has largely been ignored despite evidence that it poses a serious psychosocial problem for many men and women and those who care about them (Quadland, 1985). However, clinicians do not ordinarily address sexual addiction presented by their clients because of a lack of clarity about the phenomenon and reimbursement issues. The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV;* American Psychiatric Association, 1994) does not sufficiently address sexual addiction in its spectrum of problematic sexual behaviors. Related to this, psychiatric providers must use the *DSM-IV* criteria to ensure monetary reimbursement. However, a lack of clarity remains in behavioral medicine about this phenomenon.

Koehler and Manley (2001), practicing clinical sexologists, have identified two patterns of sexual behavior found in sexual addiction, restrictive and excessive sexual behaviors. They have proposed these patterns be included in the next revision of the *DSM*, along with a new diagnostic classification, sexual behavior disorders

Carol Coleman-Kennedy, RN, CS, PMH-NP, MSN, is an advanced practice nurse at Dignity Geropsychiatry, Inc, and a clinical instructor at the University of Arkansas for Medical Sciences-School of Nursing in Little Rock, Arkansas.

Amanda Pendley, RN, CS, PMH-NP, MSN, is an advanced practice nurse at Trover Foundation Center for Behavioral Health in Madisonville, Kentucky, and a clinical instructor at Vanderbilt University School of Nursing in Nashville, Tennessee.

Reprint requests: Amanda Pendley, RN, CS, PMH-NP, MSN, 360 Windy Hill Rd, Madisonville, KY 42431.

Copyright © 2002 by the American Psychiatric Nurses Association.

1078-3903/2002/$35.00 + 0 ***66/1/128827***
doi:10.1067/mpn.2002.128827

Table 1. Indicators of Healthy and Addictive Sexual Behaviors

Healthy sexual behavior	Addictive sexual behavior
Mutual consent (free will)	Coercion, victimization, force
Behavior is a want or desire	Behavior is a compulsion for instant gratification
Fulfilling, enhancing, mood stabilizing	Associated with severe mood shifts
Personal interchange of emotion	Impersonal and emotional detachment
Rare negative consequences	Negative consequences
Enhanced self-worth	Negative self-worth, shame, guilt
Sexual behavior is fulfilling, satiating	Lack of satiation, tolerance
Balanced sexual behavior	Erratic sexual behaviors (excessive vs. anorexic)

(Koehler & Manley, 2001). A *DSM* modification would provide guidance to clinicians on how to appropriately assess, diagnose, document, and treat problematic sexual behavior disorders and allow for legitimate reimbursement.

HEALTHY VERSUS ADDICTIVE SEXUAL BEHAVIORS

Knowledge of healthy and addictive sexual behaviors can assist clinicians in recognizing sexual addiction. Distinct differences exist between healthy and addictive sexuality (Table 1). Healthy sexuality is characterized by a mutual interchange of emotion between two consenting persons where sex is a want or desire but not necessarily a compulsive need. In contrast, sexual addiction is often characterized by a lack of free will or mutual consent between partners. In some cases, the partner of a sex addict may be coerced or forced into the sexual act. Examples of nonconsensual sexual behaviors include exhibitionism, frotteurism, voyeurism, pedophilia, and rape. The sex addict uses sex as a coping mechanism for emotional turmoil.

Addictive sexual behavior is consistently devoid of emotional closeness and is characterized by obsessive self-gratification. This is evidenced in sexual behaviors done in isolation such as compulsive masturbation, pornography, and fantasy sex. Arterburn and Stoeker (2000) stated, “Even regarding sex involving a partner, the partner isn’t really a ‘person’ but a cipher, an interchangeable part in an impersonal, almost mechanical, process. The most intimately personal of human behaviors becomes utterly impersonal” (p. 28). Pursuit of or engagement in each sexual experience is associated with anxiety and nervousness, followed by severe mood shifts (Carnes, 1991). Over time, the sexual behaviors may become erratic, fluctuating between excessive and anorexic sexual activities (Koehler & Manley, 2001). Participants, both the addict and the partner, feel increasingly degraded and victimized. As a result, they experience low self-worth and shame, which are the impelling forces that stimulate the cycle to repeat itself. Negative consequences, tangible and intangible, are the price tags associated with addictive sex.

Addictive sexual behavior is consistently devoid of emotional closeness and is characterized by obsessive self-gratification.

NEUROCHEMISTRY OF ADDICTIVE DISORDERS

Addictions have been divided into three categories: (a) arousal, (b) satiation, and (c) fantasy addictions. Milkman and Sunderwirth (1987) compared sexual addiction to other addictions, stating that sex addicts are primarily affected by the neurochemistry associated with arousal. Satiation addictions include alcohol, hypnotics, food, and sedatives. Marijuana and lysergic acid diethylamide are examples of fantasy addictions. Sexual addiction is classified as an arousal addiction because its effect on the brain is similar to the effects of cocaine, amphetamines, compulsive gambling, and risk-taking behaviors. Sexual addiction, however, profoundly influences each of these pleasure planes: arousal, satiation, and fantasy (Milkman & Sunderwirth, 1987; Nakken, 1996). A chemical explanation reveals why detoxification from sex addiction poses a tremendously difficult withdrawal and recovery process. Sex addicts lack the ability to cope with their emotional pain and use sexual fantasy and obsession, often combined with substances, as primary coping mechanisms. Similar to substance addicts, sex addicts experience tolerance, that is, the continual need to increase the amount of time spent in performance of sexual behavior to cope with emotional pain.

The activities of sexual behavior are pleasurable because of a high release of endogenous neuropeptides (e.g., endorphins and enkephalins). Researchers posit that the receptors in the brain that bind exogenous chemicals are the same receptors that bind these endogenous neuropeptides that produce the euphoria described with behavior addictions. Milkman and Sunderwirth (1987) maintain that the distinction between internally or externally induced alterations of mood, thought, or behavior is misleading. People do not become addicted to drugs or mood-altering behaviors as such but rather to the sensations of pleasure that can be achieved through them. People can become physically dependent on the experiences of arousal, satiation, or fantasy, independent of whether the capsule for trans-

port is a substance or an activity (Milkman & Sunderwirth, 1987). Neuroscientists now believe addictions are a result of chemical deficiencies in the medial forebrain bundle area of the brain's mesolimbic system. This area is known as the pleasure pathway. According to Brick and Erickson (1998), "Scientists now believe that all drugs and social experiences that produce pleasure act on this pathway" (p. 162). To suggest that addiction can involve only chemicals external to the body is to dismiss the sex addict's reality and overlooks a rapidly expanding body of scientific literature (Carnes, 1991).

ASSESSMENT

Assessment and diagnosis of sexual addiction can occur in several phases, beginning with the general psychiatric assessment. Ideally, the clinician will assess for sexual addiction when assessing for substance addiction. Indicators of sexual and substance addictions will often be revealed when the person is questioned about family, medical, psychosocial, legal, and relationship histories. The practitioner who recognizes these indicators may use the algorithm shown in Figure 1 for identifying sexual addiction, other sexual disorders, or substance use disorders. Other concurrent psychiatric disorders may be revealed in the assessment phase.

Investigation of the family history is the best method of identifying dysfunctional family attachments, a primary source of sexual addiction. During the initial evaluation, use of a genogram can be an invaluable tool for identifying the multigenerational transmission process of addictive disorders seen in successive dysfunctional families (Boone, 2000; Goldenberg & Goldenberg, 1996). Dysfunctional attachments with the major caregiver during child-rearing is a hallmark finding for both substance and sexual addictions (Carnes, 1991; Earle & Crow, 1998; Kasl, 1989; Mellody, 1992; Nakken, 1996). Earle and Crow identified negative childhood experiences such as neglect, abuse, or abandonment as probable related factors in sexual addiction. Because of these experiences, the sex addict fails to develop appropriate skills for communicating with others. A lack or fear of intimacy is often the result of dysfunctional role-modeling by parents or caregivers. Social learning theorists and Murray Bowen, the developer of family systems theory, assert dysfunctional sexual attitudes and behaviors are learned early in family life. For example, using sexual behaviors to manipulate power in relationships is learned from the modeling a child experiences from other family members (Goldenberg & Goldenberg, 1996; Gerety, Wasli, & McFarland, 1997).

Kasl's (1989) model (Figure 2) illustrates childhood victimization that occurs as a result of physical, emotional, or sexual abuse or neglect and results in violation of one's personhood. Subsequently, a negative belief system develops in the child, which further develops into a negative operational belief in adulthood. Examples of negative core beliefs include: "I am defective, I am shameful, I am unlovable, and I will always be abandoned" (Kasl, 1989, p. 45).

Operational beliefs lead to actions such as codependency and sexual addiction, which provide escape from negative core beliefs. The goal is to regain power and control to overcome anxiety and restore a sense of self (Kasl, 1989). Many sex addicts identify sex as a means of having power over another person. This compulsive drive for control often progresses to conflict, rage, violence, or crime (Carnes, 1991, 1997; Dayton, 2000).

Many sex addicts identify sex as a means of having power over another person.

The medical history is important for identifying recurrent medical complications such as sexually transmitted diseases, which are indicators of sexual addiction. Carnes (1991) found that 10% to 64% of sex addicts surveyed reported indiscreet sexual behaviors such as having affairs, swapping partners, performing anonymous or group sex, or one-night stands; patronizing escort services, saunas, massage parlor, or rap lounges; or paying for sexual activity. Other problems revealed in the medical history include sexual trauma or injury, physical exhaustion, hypertension, infection, unwanted pregnancies, and abortions (Carnes, 1991).

Dual addictions, or crossover addictions, including process or behavior addictions, often coexist with chemical dependency (Carnes, 1991; Irons & Schneider, 1994; Schneider, 1991; Straussner & Zelvin, 1997). In a study of 1,000 sex addicts admitted for inpatient treatment, 26% to 42% disclosed chemical dependence, eating disorders, compulsive working, compulsive spending, and compulsive gambling (Carnes, 1991). Relapse to substance addiction often occurs when sexual addiction remains untreated (Schneider, 1991). Kasl (1989) emphasized that many women cannot begin recovery from substance addiction until they resolve their sexual addiction. When women were asked to describe the relationship between substance addiction and sexual addiction, Kasl reported, "Their answers revealed that the two often go hand in hand. . .[but] the 'monster' was sexual addiction" (pp. 178-179). According to Kasl, two basic themes explain this relationship. Alcohol or other substances may be used to repress sexual addictive inclinations, or they may actually be a part of the sexual ritual. In sexual violence, alcohol and drugs are sometimes used to rationalize violent behavior (Carnes, 1997). Typically, the substances are used to

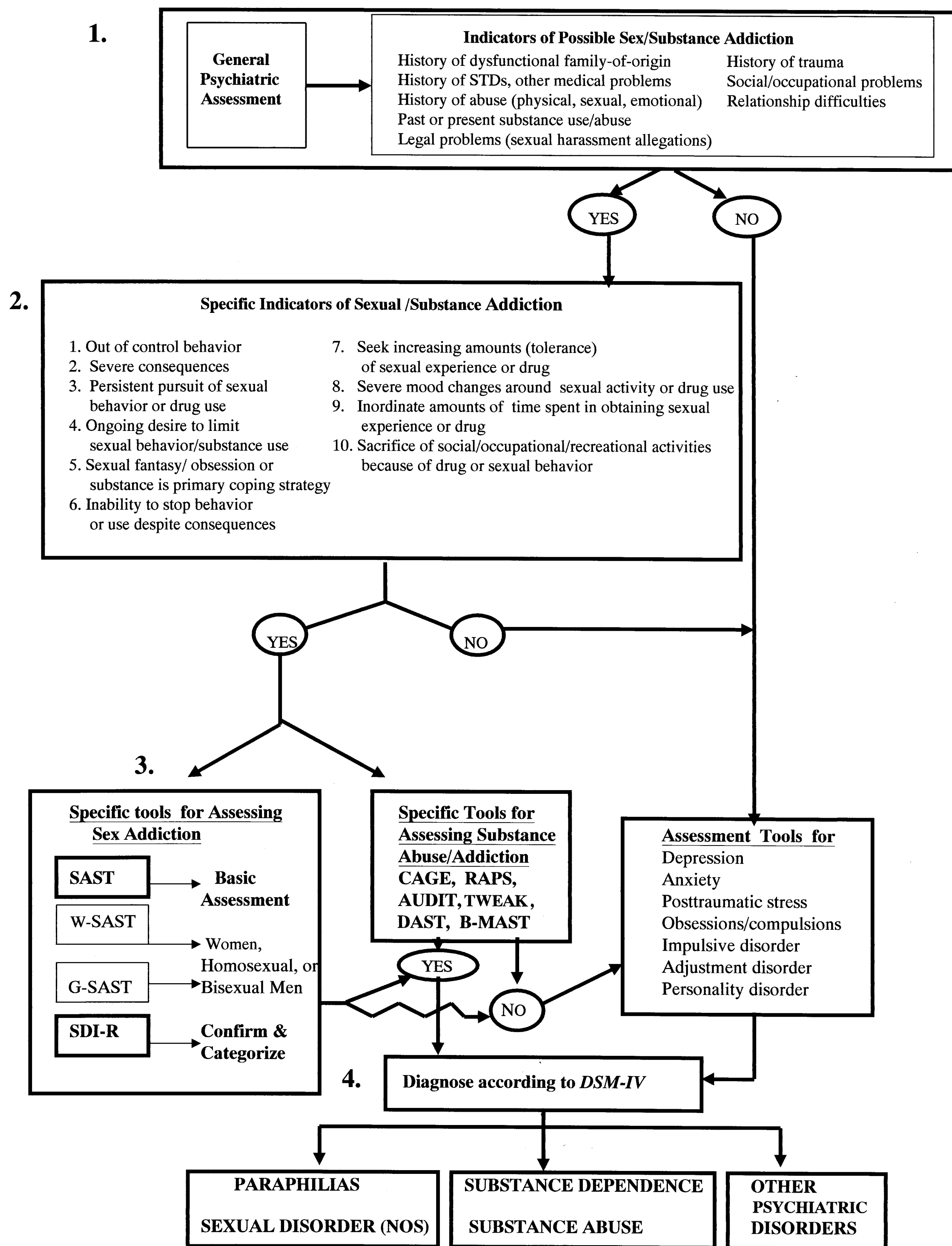

Figure 1. Algorithm for assessing and diagnosing sexual addiction. *STD*, Sexually transmitted disease; *SAST*, Sexual Addictions Screening Test; *W-SAST*, Women's SAST; *G-SAST*, Gay or Bisexual Male SAST; *SDI-R*, Sexual Dependence Inventory-Revised; *CAGE*, Cutting down, Annoyance by criticism, Guilty feeling, Eye-openers; *RAPS*, Rapid Alcohol Problem Screen; *AUDIT*, Alcohol Use Disorders Identification Test; *TWEAK*, Tolerance, Worried, Eye-opener, Amnesia, C(K)ut down; *DAST*, Drug Abuse Screening Test; *B-MAST*, Brief-Michigan Alcohol Screening Test; *DSM-IV*, Diagnostic and Statistical Manual (4th edition); *NOS*, not otherwise specified.

Figure 2. Model illustrating how childhood victimization can lead to sexual addiction and sexual codependency. Adapted with permission from Charlotte Kasl, PhD.

produce a euphoria that medicates or relieves emotional pain. These statistics amplify the coexisting nature of these addictive disorders and the need to assess for sexual addiction while assessing for substance use disorders.

Relationship difficulties with one's partner is another indicator that sexual addiction may be present. Carnes' (1991) survey revealed that 57% of sex addicts admitted having sexual affairs outside their primary relationship. As a result, partners may actually be the initiators in seeking help. Partners of sex addicts often feel the relationship problems are due to their own inadequacies. Sexual anorexia with the partner is a familiar theme among sex addicts (Weiss, 1998). The partner feels neglected while the sex addict is participating in sexual behaviors outside of the relationship. Sometimes the partner feels confused by the sex addict's efforts to coerce him or her into participating in sexual activities outside of the relationship, such as group sex or swapping partners (Carnes, 1991). Anger, hostility, and trauma are also experienced, and these behaviors can be passed down to the next generation (Carnes, 1997; Dayton, 2000; Goldenberg & Goldenberg, 1996; Nakken, 1996).

Sex addicts often neglect their work obligations, social functions, or family responsibilities in an effort to pursue or participate in sexual behaviors. A therapist may hear a patient state that he was fired from his job, that his wife left him, or that he missed his child's school events. The need to act out sexually takes precedence over important activities in the person's daily life. Sex addicts report excessive amounts of time are spent in seeking the opportunity to act out sexually (Carnes, 1991). The compulsion sometimes escalates to the point of legal ramifications or public humiliation as a result of socially and legally intolerable behaviors such as masturbating in public places or using a powerful position to exploit or be sexual with another person. Common examples include the misuse or abuse of power by ministers, employers, physicians, and therapists. Inappropriate exposure of one's genitals in showers, locker rooms, or public places was a common practice found in the Carnes survey. Forcing sexual activity on others, including minors, was also reported, thus eventually leading to incarceration for their sexual offenses.

Specific Indicators

Once initial indicators for addictive disorders are revealed in the general psychiatric assessment, the

Table 2. Ten Specific Signs of Sexual Addiction

1.	Out of control sexual behavior
2.	Severe consequences
3.	Inability to stop (despite negative consequences)
4.	Persistent pursuit of high-risk behavior
5.	Ongoing desire or effort to limit behavior
6.	Sexual behavior is primary coping strategy
7.	Seeking increased amounts (tolerance)
8.	Severe mood changes around sexual activity
9.	Excessive time spent in obtaining sex, being sexual, or recovering from sexual experience
10.	Important social, occupational, and recreational activities are sacrificed or reduced

Note. Adapted from *Don't Call it Love: Recovery from Sexual Addiction* (p. 11, 12), by P. Carnes, 1991, New York: Bantam Books.

practitioner can use detailed questioning to seek specific signs of addiction, including (a) out-of-control sexual or substance use behaviors, (b) severe consequences around these behaviors, (c) ongoing desire to limit behaviors, (d) inability to stop specific sexual or substance use behaviors, and (e) symptoms of tolerance and withdrawal. On the basis of clinical experience and research, Carnes (1991) identified 10 signs that indicate the presence of sexual addiction (Table 2).

Tolerance and withdrawal are evident in the sex addict's attempt to control his or her sexual behaviors. Sexual addiction leads the sex addict to choose partners and sexual practices injudiciously as he or she seeks more of this temporary emotional fix. This concept is known as *tolerance* in addictive terminology. Most sex addicts reported having sex even though they truly did not want to or feel like it. More than 90% of sex addicts reported obsessive thoughts or fantasies of sexual experiences, and more than 70% reported withdrawal symptoms between sexual episodes. These included nervousness, insomnia, sweats, nausea, increased heart rate, shortness of breath, or fatigue (Carnes, 1991; Nakken, 1996). Negative consequences are consistently identified as a result of sexually addictive behaviors. Paramount consequences are losses such as family, career, finances, time, productivity, reputation, and health, to name a few. A survey of 934 sex addicts revealed that greater than 70% reported denial or rationalization for the consequences of sexual behaviors (Carnes, 1991). The sex addict desires to stop compulsive sexual behaviors but cannot stop despite these negative consequences (Arterburn & Stoeker, 2000; Brick & Erickson, 1998; Carnes, 1991; Nakken, 1996). Weiss (1998) stated that the sex addicts' acting out progresses through various levels, culminating in out-of-control behavior (p. 33-44).

Tolerance and withdrawal are evident in the sex addict's attempt to control his or her sexual behaviors.

Assessment Tools

When general and specific indicators of sexual addiction are revealed, the clinician can then use specific assessment tools for confirming sexual addiction and substance addiction. The most basic diagnostic tool for identifying problematic sexual behaviors is Carnes' (1989) Sexual Addictions Screening Test (SAST) (Table 3). Manley (as cited in Little, 1991) warns, however, that the SAST was developed primarily for screening men sex addicts, and some women sex addicts have actually scored low on the SAST. In addition, the tool may not be suitable for screening homosexual or bisexual men sex addicts. Adaptations of the SAST have been developed for screening homosexual or bi-sexual male sex addicts (G-SAST) and screening female sex addicts (W-SAST) (A. Corley & S. O'Hara, personal communication, April 11, 1999). Although scientific validity and reliability of these tools have not yet been determined, the G-SAST and W-SAST appear to be good clinical tools for identifying problematic sexual behaviors. Once sexual addiction has been identified, the Sexual Dependency Inventory-Revised (SDI-R) can be used for identifying the extent of sexual addiction (Carnes & Delmonico, 1997). Table 4 lists assessment tools that may be helpful in identifying problematic sexual behaviors.

Because 40% to 50% of sex addicts appear to have addictions to alcohol or other substances, it is essential for the clinician to assess for these disorders with the use of valid and reliable diagnostic screening instruments. Dual addictions are complicated to treat, and identification will affect treatment decisions. Specific screening tools the practitioner can use when assessing for substance abuse and dependence can be found in Table 5. In a comparative study of short screening instruments, the Rapid Alcohol Problem Screen appears to be particularly appealing for clinical use. It is a brief, user-friendly tool that is both sensitive and specific for identifying problem drinkers across ethnic and gender subgroups and in various regions of the country (Cherpitel, 1997). Another brief, yet sensitive tool is the CAGE (**C**utting down, **A**nnoyance, **G**uilty feeling, and **E**ye-openers) questionnaire (Ewing, 1984).

Evaluating for other psychiatric problems is necessary. Although depression and anxiety are the symptoms most often reported by sex addicts, other psychiatric problems are often encountered in conjunction with sex addiction and warrant specific assessments. These include posttraumatic stress disorder, personality

Table 3. Sexual Addiction Screening Test

1. Were you sexually abused as a child or adolescent?
2. Have you subscribed to or regularly purchased sexually explicit magazines?
3. Did your parents have trouble with sexual behavior?
4. Do you often find yourself preoccupied with sexual thoughts?
5. Do you feel that your sexual behavior is not normal?
6. Does your spouse (or significant other) ever worry or complain about your sexual behavior?
7. Do you have trouble stopping your sexual behavior when you know it is inappropriate?
8. Do you ever feel bad about your sexual behavior?
9. Has your sexual behavior ever created problems for you or your family?
10. Have you ever sought help for sexual behavior that you did not like?
11. Have you ever worried about people finding out about your sexual behavior?
12. Has anyone been hurt emotionally because of your sexual behavior?
13. Are any of your sexual activities against the law?
14. Have you made promises to yourself to quit some aspect of your sexual behavior?
15. Have you made efforts to quit a type of sexual behavior and failed?
16. Do you have to hide some aspects of your sexual behavior from others?
17. Have you attempted to stop some parts of your sexual activities?
18. Have you ever felt degraded by your sexual behavior?
19. Has sex been a way for you to escape from your problems?
20. When you have sex, do you feel depressed afterward?
21. Have you felt the need to discontinue a certain form of sexual activity?
22. Has your sexual activity interfered with your family life?
23. Have you been sexual with minors?
24. Do you feel controlled by your sexual desire?
25. Do you think that your sexual desire is stronger than you are?

Note. Affirmative answers to 13 or more questions is strongly suggestive of sexual addiction. Reprinted with permission from Patrick J. Carnes, PhD, CAS.

disorders, obsessive-compulsive disorders, impulse control disorders, and adjustment disorders (Brick & Erickson, 1998; Carnes, 1991; Naaken, 1996;). Although discussion of these psychiatric issues is beyond the scope of this article, detailed assessment and diagnosis of these problems are essential for later individualized treatment and planning.

DIAGNOSIS

Once sexual addiction is identified, categorization from the *DSM-IV* (American Psychiatric Association, 1994) is helpful in diagnosing and directing treatment for the heterogeneity of patients presenting with symptoms. Although the *DSM-IV* is limited for the diagnosis of sexual addiction, *Sexual and Gender Identity Disorders* is the current section applicable to sexual behavior disorders. It is subdivided into three basic criteria sets: *sexual dysfunctions, paraphilias*, and *gender identity disorders.* A fourth category, *sexual disorder, not otherwise specified* is reserved for coding a sexual disturbance that does not meet the criteria for the three basic criteria sets.

Some addictive sexual disorders may be classified as a paraphilia. “Paraphilia means abnormal or unnatural attraction. The paraphilias are characterized by compulsive or impulsive sexual behaviors. In descending order, the most common paraphilias are pedophilia, exhibitionism, voyeurism, and frotteurism” (Morrison,

Table 4. Screening Tools for Sexual Disorders

Sexual Addiction Screening Test (SAST)
- Carnes, P. (1989). *Contrary to love*. Minneapolis: CompCare.

Sexual Dependence Inventory (SDI-R)
- Carnes, P., & Delmonico, D. (1997). *Sexual Dependency Inventory-Revised*. Wickenburg, AZ: The Meadow Institute.

The Gay and Bisexual Male Sexual Addiction Screening Test (G-SAST)
- Corley, A. (1999, April). The Gay and Bisexual Male Sexual Addiction Screening Test (G-SAST). Paper presented at the annual conference of the National Council on Sexual Addiction and Compulsivity, St. Louis, MO.

Women’s Sexual Addiction Screening Test (W-SAST)
- O’Hara, S. (1999, April). The Women’s Sexual Addiction Screening Test (W-SAST). Paper presented at the annual conference of the National Council on Sexual Addiction and Compulsivity, St. Louis, MO.

Online Sexual Addiction Questionnaire (OSA-Q)
- Putnam, D. E. (1999). Online sexual addiction questionnaire (OSA-Q). Retrieved from: http://www.onlinesexaddict.com/osaq.html

Sexual Behaviors Inventory for Male (SBI-M) and Female (SBI-F)
- Bentler, P.M. (1968). Heterosexual behavior assessment-I Males, *Behavior Research and Therapy, 6,* 21–25.
- Bentler, P.M. (1968). Heterosexual behavior assessment-II Females, *Behavior Research and Therapy 6,* 27–30.

Table 5. Screening Tools for Substance Use Disorders

CAGE (**C**utting down, **A**nnoyance by criticism, **G**uilty feeling, **E**ye-openers)
Ewing, J.A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association, 252,* 1905-1907.
Brief-Michigan Alcohol Screening Test (B-MAST)
Pokorny, A., Miller, B., & Kaplan, H. (1972). The Brief Mast: A shortened version of the Michigan Alcoholism Screening Test. *American Journal of Psychiatry, 129,* 342.
Tolerance, **W**orried, **E**ye-opener, **A**mnesia, C(**K**)ut down (TWEAK)
Russell, M., Martier, S.S., Sokol, R.J., Mudar, P., Botoms, S., Jacobson, S., & Jacobson, J. (1994). Screening for pregnancy risk-drinking. *Alcoholism: Clinical and Experimental Research, 18,* 1156-1161.
Alcohol Use Disorders Identification Test (AUDIT)
Saunders, J.B., Aasland, O.G., Babor, T.F., De La Fuente, J.R., & Grant, M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption. II. *Addiction, 88,* 791-804.
Rapid Alcohol Problem Screen (RAPS)
Cherpitel, C. J. (1997). Brief screening instruments for alcoholism. *Alcohol Health and Research World, 21,* 348-351.
Drug Abuse Screening Test (DAST)
Skinner, H.A. (1982). The drug abuse screening test. *Addictive Behaviors, 7,* 363-371.

Table 6. Diagnostic Criteria for Classification of Paraphilias

Paraphilias	Intense sexual desire, fantasy, or behavior
302.4 Exhibitionism	Genital self-exposure to an unsuspecting stranger
302.81 Fetishism	Sexual use of inanimate objects (shoes, underwear)
302.89 Frotteurism	Touching or rubbing against a nonconsenting person
302.2 Pedophilia	Sexual activity with a sexually immature child
302.83 Sexual masochism	Act of being tormented, humiliated, or made to suffer
302.84 Sexual sadism	Real acts of tormenting or humiliating another person
302.3 Transvestic fetishism	Cross-dressing
302.82 Voyeurism	Act of watching an unsuspecting person who is naked, disrobing, or having sex
302.9 Paraphilia, not otherwise specified	Does not meet the criteria for any of the specific categories of paraphilias. Examples are partialism, telephone scatologia, zoophilia, necrophilia, klismaphilia, coprophilia, and urophilia.

Note. Adapted from *DSM-IV Made Easy: The Clinicians Guide to Diagnosis* (p. 362-386), by J. Morrison, 1995, New York: Guilford Press.

1995, p. 360). Most paraphilias begin in adolescent males who fantasize sexual contact with their victims. They often act upon those fantasies. The sexual fantasy or behaviors involve objects, humiliation, and suffering of partner and nonconsenting persons including children (Morrison, 1995). Classification criteria are based on identification of the specific intense sexual desires, fantasies, or behaviors. For example, voyeurism involves "intense sexual desires, fantasies, or behaviors concerning the act of watching an unsuspecting person who is naked, disrobing, or having sex" (Morrison, p. 378). See Table 6 for diagnostic classification criteria of addictive sexual disorders.

The diagnosis currently most often used for sexually addictive disorders is one that does not meet the criteria for a paraphilia or either of the other criteria sets and is categorized as *sexual disorder, not otherwise specified* (Schneider & Irons, 1996). In order for the sexual behavior to be considered diagnostic, the problematic sexual behavior must occur for at least 6 months and must cause clinically significant distress or impairment in social or occupational functions. An example given for *sexual disorder, not otherwise specified* is "distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used" (American Psychological Association, 1994, p. 638).

SUMMARY

The impact of sexual addiction in society highlights the importance for developing a better understanding of sexual behavior disorders and applying that knowledge to the psychiatric mental health environment. Its comparable qualities and symbiotic relationship with substance addiction warrants evaluation in substance-addicted persons. This article discussed practical guidelines for recognizing, assessing, and diagnosing sexual addiction while evaluating a person for a substance addiction. An algorithm was presented to guide advanced psychiatric practitioners through progressive stages of assessment and diagnosis.

Initial assessment involves the recognition of general indicators of possible substance or sexual addiction. When revealed, these indicators should prompt practitioners to assess for specific indicators of sexual or substance addictions through further detailed questioning and the use of diagnostic assessment tools for addictive disorders and other coexisting psychiatric disorders. Finally, diagnoses are made with the *DSM-IV* diagnostic criteria for sexual disorders, substance use disorders, and other psy-

chiatric disorders. Actual diagnoses can then be used as a guide for treatment of these disorders.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. (4th. ed.). Washington, DC: Author.

Arterburn, S., & Stoeker, F., with Yorkey, M. (2000) *Every man's battle: Winning the war on sexual temptation: One victory at a time*. Colorado Springs, CO: Waterbrook Press.

Brick, J., & Erickson, C. (1998). *Drugs, the brain, and behavior: The pharmacology of abuse and dependence*. New York: The Haworth Medical Press.

Boone, D. (2000). Violence and crime: A vicious cycle. *Professional Counselor, 2*(14), 31-34.

Carnes, P. (1989). *Contrary to love*. Minneapolis, MN: CompCare.

Carnes, P. (1991). *Don't call it love: Recovery from sexual addiction*. New York: Bantam Books.

Carnes, P. (1997). *The betrayal bond: Breaking free of exploitive relationships*. Deerfield Beach, FL: Health Communications.

Carnes, P., & Delmonico, D. (1997). *Sexual Dependency Inventory-Revised*. Wickenburg, AZ: The Meadow Institute.

Cherpitel, C.J. (1997). Brief screening instruments for alcoholism. *Alcohol Health and Research World, 21*, 348-351

Dayton, T. (2000). Relationships in conflict: Healing anger and hostility from unresolved trauma and addiction issues. *Professional Counselor, 2*(14), 46-49.

Ewing, J.A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association, 252*, 1905-1907.

Earle, R., & Crow, G. (1998). *Lonely all the time: Recognizing, understanding, and overcoming sex addiction of addicts and codependents*. New York: Pocket Books.

Gerety, E., Wasli, E., & McFarland, G. (1997). Sexual and gender identity disorders. In E. Cotllier, T. Gibbons, M. Zuccarini (Eds.) *Nursing diagnoses & process: In psychiatric mental health nursing* (3rd ed., p. 325-341). Philadelphia: Lippincott-Raven.

Goldenberg, H., & Goldenberg, I. (1996). Bowen's approach to theory and practice. In C. Verduin, & P. Vienneau, (Eds.) *Family therapy: An overview* (4th ed., p. 165-186). Pacific Grove, CA: Brooks/Cole.

Irons, R., & Schneider, J. (1994). Sexual addiction: Significant factor in sexual exploitation by health care professionals. *Sexual Addiction & Compulsivity, 1,* 198-213.

Kasl, C. (1989). *Women, sex and addiction: A search for love and power*. New York: Harper & Row.

Koehler, J., & Manley, G. (March, 2001). *Analysis of sexual excessivity and restriction in 796 hospitalized patients*. Paper presented at the DSM Symposium, Vanderbilt University Medical Center. Nashville, TN.

Levine, M., & Troiden, R. (1988). The myth of sexual compulsivity. *Journal of Sex Research, 25*, 347-363.

Little, M. (1991, June). Compulsive sex: From masturbation to disposable lovers, Americans are using sex to cope. *Tennessee Nurse*, 28-29.

Manley, G. (1995). Healthy sexuality: Stage III recovery. *Sexual Addiction & Compulsivity, 2*, 157-183.

Mellody, P. (1992). *Facing love addiction: Giving yourself the power to change the way you love*. San Francisco: Harper SanFrancisco.

Milkman, H., & Sunderwirth, S. (1987). *Craving for ecstasy: The consciousness and chemistry of escape*. New York: Lexington Books.

Morrison, J. (1995). *DSM-IV made easy: The clinician's guide to diagnosis*. New York: The Guilford Press.

Nakken, C. (1996). *The addictive personality: Understanding the addictive process and compulsive behavior*. (2nd ed.). Center City, MN: Hazelden.

Quadland, M. (1985). Compulsive sexual behavior: Definition of a problem and an approach to treatment. *Journal of Sex & Marital Therapy, 11,* 121-132.

Schneider, J. (1991). How to recognize the signs of sexual addiction: Asking the right questions may uncover serious problems. *Postgraduate Medicine, 90*, 171-182.

Schneider, J., & Irons, R. (1996). Differential diagnosis of addictive sexual disorders using the *DSM-IV*. *Sexual Addiction & Compulsivity, 3*, 7-21.

Straussner, S.A., & Zelvin, E. (Eds.). (1997). *Gender and addictions: Men and women in treatment*. Northvale, NJ: Jason Aronson.

Weiss, D. (1998). *The final freedom: Pioneering sexual addiction recovery*. Fort Worth, TX: Discovery Press.