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A case for the sexual impulsivity perspective for describing issues of sexual control

Abstract

Currently, existing sexual dysfunction information has centered upon sexual desire and/or sexual response. Unfortunately, the concern over what has been referred to as sexual compulsivity (Quadland, 1985), sexual addiction (Schwartz & Brasted, 1985; Carnes, 1983), and sexual impulsivity (Barth & Kinder, 1987) had been met with sparse research at best. Much of what is now available is based upon historical discussions of hyperactive sexuality or nymphomania and satyriasis, the former receiving, the plurality of attention despite its lack of an operational definition and its sexist and judgmental connotation (Quadland, 1985).

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A CASE FOR THE SEXUAL IMPULSIVITY PERSPECTIVE FOR DESCRIBING ISSUES OF SEXUAL CONTROL

A Research Paper

Presented to

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and Counseling

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In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

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by

Barton A. Wieden

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Currently, existing sexual dysfunction information has centered upon sexual desire and/or sexual response. Unfortunately, the concern over what has been referred to as sexual compulsivity (Quadland, 1985), sexual addiction (Schwartz & Brasted, 1985; Carnes, 1983), and sexual impulsivity (Barth & Kinder, 1987) had been met with sparse research at best. Much of what is now available is based upon historical discussions of hyperactive sexuality or nymphomania and satyriasis, the former receiving the plurality of attention despite its lack of an operational definition and its sexist and judgmental connotation (Quadland, 1985).

As such nymphomania is not a new disorder but actually a very old one (Levine, 1982). A typical nineteenth century description has depicted it as the most deplorable condition in which the female victim is without any control over her sexual desire resulting in a sacrifice of all that might be considered feminine (Kent, 1879 cited in Levine, 1982).

Control or lack thereof, over sexual behavior has received more attention within the last seven years largely due to the increased awareness of the life threatening AIDS virus which is sexually transmitted. As a direct result, many persons have attempted to curtail the number of sexual partners they engage in

order to reduce their own personal risk to AIDS; it is many of these persons' difficulty in reducing their sexual partners and seeking out the help of professionals that has spawned on much of the current literature on sexual control issues (Quadland, 1985).

Literature within the medical field on sexual control issues has attempted to explore both cultural and biological factors in an analysis of the sexual activity of modern American teenagers (Goodman, 1976). A common perspective within the medical field rests with the thesis of a biological libido. The main point has centered on androgen levels as crucial determinants to the development of the sex drive (Stoller, 1968). Another point of concern brought out from the medical field is the modern day compression of childhood via the average age and menarche having dropped three to four years the past century. As such, the earlier the potential for pregnancy the greater the concern among parents for the sexual activity of their children (Goodman, 1976).

The implications for counselors in terms of sexual control issues are staggering. As increasing numbers of persons turn to the counseling field for help in controlling their sexual behavior, or that of their children, it is imperative that a common definition and

understanding of sexual control issues exists. Such an understanding, I feel, needs to address the current literature in terms of biological, sociological, and psychological factors before successful treatment modality can be utilized.

The purpose of this paper is to offer a review of one modern perspective on the issue of sexual control that, in my opinion, best accounts for all previously mentioned factors as well as the current understanding of mental pathology that has been outlined in the Diagnostic and Statistical Manual Revised (DSM-III R, 1980) by the American Psychiatric Association. The view that I have chosen to focus on has been developed by Barth and Kinder (1987) and is referred to as the sexual impulsivity perspective.

Sexual Impulsivity

According to Barth and Kinder (1987), the terms compulsive sexual behavior, sexual addiction, and hypersexuality have all been used to describe the same situation. However, they pointed out, the vital issue is an individual's perceived inability to control his or her own sexual impulses.

To focus only on frequency, promiscuity, or social acceptability of sexual behavior ignores the perceived lack of control such individuals seem to suffer. They

introduced the concept of sexual impulsivity in referring to the behavioral patterns that previous terms have not accurately described.

Barth and Kinder (1987) described a general agreement of previous authors in the cycle of sexual activity used to cover-up difficult emotions such as" loneliness followed by short term release then guilt over the sexual release and finally, the return to the sexual activity (Schwartz & Brasted, 1985; Quadland, 1985; Levine, 1982).

Barth and Kinder (1987) pointed out that the area of greatest disagreement seems to rest in the type of sexual behavior utilized by sexually impulsive individuals. Schwartz and Brasted (1985) claimed that these individuals find conventional intercourse undesirable and prefer deviations such as transvestitism, fetishes, voyeurism, exhibitionism, rape, and child molestation. However, Orford (1978) and Quadland (1985) claimed that the disorder can be manifested through any form of sexual behavior, ranging from personal fantasizing to violent criminal acts. In regard to the preferences of sexually impulsive individuals, Quadland discussed only homosexuals, Schwartz and Brasted only heterosexuals, and Carnes (1983) devoted two pages of his book to discussing

homosexuals while 183 pages are devoted to heterosexuals.

Barth and Kinder (1987) pointed out that Quadland (1985) was the only author to have imperically described the complexities of sexual impulsivity. However, they also point out numerous weak points to this study such as the lack of generalizable results due to all the subjects being homosexual males that presented themselves for counseling. Quadland was unable to find any significant differences in terms of neurotic symptoms, reporting of desired sexual partners, desired frequency of sexual activity, or desired amount of group sex. Two things that Quadland did find were that while desired number of sexual contacts remained insignificantly different, actual numbers of contacts were higher among the sexually impulsive group. In effect, impulsivity was shown to be the determining factor in the number of actual sexual contacts rather than desire.

Therapy Conditions

In terms of therapy conditions for sexual impulsivity, the vast majority of authors reviewed support a group therapy modality (Orford, 1978; Barth & Kinder, 1987; Carnes, 1983; Levine, 1982; Schwartz & Brasted, 1985). In essense, the effectiveness of

social support in the group threat is believed crucial to the confronting of the social isolation so typical of sexually impulsive individuals. Barth and Kinder point out that Schwartz and Brasted's six stage group model is the most detailed treatment approach yet offered. Unlike Carnes' model, which utilized an Alcoholics Anonymous Twelve Step approach to fit the sexually impulsive individual and a reliance on an individualized notion of "God," Schwartz and Brasted directly focus on combating religious beliefs that tend to promote guilt, shame, and low self-esteem.

In terms of treatment, Schwartz and Brasted (1985) noted, all addictions are chronic disorders requiring a perspective focusing on rehabilitation rather than cure. Treatment is considered difficult and prognosis is variable. Many such individuals are ex-alcohol and drug abusers and simply present a new or even dual diagnosis.

Also similar to alcohol and drug addictions, the first step involved was stopping the undesirable sexual behavior. Aversive behavior techniques of covert sensitization and fantasy satiation are noted by Schwartz and Brasted as options to aid in stopping the targeted sexual behavior.

The second step, "opening the channel," involved

dissolving the chain of rationalization and denial to gain admission of the full dynamic range of the problem. Here group treatment aids in boosting self-esteem and sanctioning "normal" sexual behaviors such as masturbation.

Remembering that anxiety led to the situation, alternative coping techniques are offered to help find self-enhancing methods of dealing with anxiety. Relaxation, socializing, exercise, problem solving, self-disclosure with an intimate partner, and self-assertivenes, are explored and encouraged in weekly therapy sessions (Schwarz & Brasted, 1985).

Through weekly psychotherapy focusing on cognitive-behavioral techniques aimed at reducing client helplessness, behavioral suggestions are offered to instill feelings of powerfulness within the client. In showing the concerned individual that he or she can be responsible for their own actions, and simultaneously do not have to blame others, irrational beliefs that support the negative behaviors can be removed. Eventually the individual is taught effective methods of communication leading to problem solving of guilt, shame, and self denial. The problematic behavior, in effect, is discontinued through elimination of the compelling forces that guide it.

Ultimate success, according to Schwartz and Brasted (1985), rested in the ability of the client to replace the thrill of self-destructive behavior with the rewards of genuine intimacy.

In terms of actual effectiveness in the treatment of sexual control concerns, Quadland (1985) has demonstrated, from his study of homosexual and bisexual males, that significantly reduced sexual contacts six months after treatment were found. This same group was also found to be significantly more likely to be involved in a primary relationship after the same period of time.

Sexual Impulsivity Contrasted to Other Definitions

Key differences can be found in contrasting the use of terms such as nymphomania (Levine, 1982) and satyriasis (Salzman, 1972) in comparison to sexual impulsivity. Satyriasis is the male equivalent of nymphomania. As such, it differs from sexual impulsivity in the same way as nymphomania; it is restricted to one gender (male) and has an acute time of onset. In addition, Salzman described abnormal duration of the involved sex act and effects of pituitary disorders in relation to the abnormal duration. In neither case do such elements find their way into the definition of sexual impulsivity.

The terms hyperlibido and hypersexuality differ from sexual impulsivity. Hyperlibido has been described as an acute affliction and is limited by its psychoanalytic roots (Datre, 1973). Hypersexuality is a rather overused term which may be used as a synonym for either satyriasis or nymphomania which, essentially, is attributed to a faulty limbic system. Hypersexuality, as defined, has been found to be more common among women (Mohan, Salo, & Nagaswami, 1975).

In the use of the term sexual addiction Carnes (1983) pointed out the similarities between sexual addiction and alcoholism. In direct contrast it may be noted that, however similar sexual control issues may be to that of the behavioral issues surrounding chemical addiction, such similarities do not overrule the original definition of addiction as a physiological dependence upon some foreign substance evidenced by the removal of that substance producing a physiological withdrawal state (DSM III R, 1980).

Sexual impulsivity involves no foreign substances or withdrawal states and as such, should not be labeled as an addiction. Addiction, as a term, should only be reserved for use in discussion of chemical dependence (Barth & Kinder, 1987).

In the use of the term sexual compulsivity

Quadland (1985) has sought to compare the related behaviors of compulsiveness to that of the perceived loss of control over sexuality that such afflicted individuals express. Again, as with sexual addiction, however similar such behaviors may appear to compulsive behavior, such similarities do not overuse the definition of compulsive behavior already in existence. Within the context of compulsive personality disorder, key elements such as perfectionism and devotion to work to the exclusion of pleasure, directly conflict with the notion of sexual compulsivity. In terms of obsessive-compulsive disorder, the behavior involved is described as unenjoyed and not seen as an end in itself but rather designed to prevent or induce a future event (DSM III R, 1980).

In the usage of sexual impulsivity a clear comparison to other impulse disorders exists. The sexual act itself is seen as an escape from current anxieties rather than from a future event. Since such an escape is intrinsically enjoyable, the label of compulsion clearly does not apply here. In short, the lack of perceived control over one's sexual issues can best be thought of as no more than a manifestation of an atypical impulse control disorder (Barth & Kinder, 1987).

In their argreement with the viewpoint presented by Barth and Kinder (1987), Levine and Troiden (1988) described an interactionist approach in their suggestion that sexual compulsion and sexual addiction are essentially therapeutic constructs. In effect, compulsion and addiction are combined with sexuality to attach stigmatizing labels to behaviors that diverge from the prevailing set of sexual standards in our current society. In essence, there is nothing intrinsically pathological in the conduct that is presently labelled as sexual compulsive or addictive. These are, indeed, elements of a personal lifestyle that might go against the grain of current societal norms, such as clothing and hair style. Terminology has been created to stigmatize those that the larger society on the whole views as abnormal. The loneliness, guilt, shame, anxiety, and lowered self-esteem experienced by such individuals actually comes from a part of their personal lifestyle that has been labelled deviant, maladaptive, and amoral by society as a whole. All the authors presented on this subject thus far have agreed that guilt and anxiety resulting from the "afflicted" individuals's behavior leads the individual into the impulsive cycle. However, only Levine and Troiden adequately describe the role that societal

norms play in reinforcing the guilt and anxiety that makes the impulsive cycle begin.

Parental Influences

One of the primary sources of societal influences is the home. Hajcak and Garwood (1988) pointed out that sexually active teenagers become sexually active due to many factors that might seem unrelated to sex. Teens looking for affection build sagging self esteem, prove masculinity or femininity, vent anger, and escape boredom through sex. Sex, in effect, becomes a coping mechanism for new sexual issues largely due to early on messages sent to children through their parents. If parents are open about sexuality with their children then a positive and healthy attitude toward sex an likely follow. In such a case, sexual needs can be dealt with through sexual activities. However, if sex is something hidden, not discussed or even treated negatively, then a negative attitude may develop with unhealthy consequences soon likely to follow. Once teens become experienced to the powerful physical and emotional arousal that sexual activity maintains, previous negative emotions can seem absorbed in the sexual activity. Over time, such individuals condition themselves to pair sexual arousal with any experienced emotional pain. The temporary relief of this pain

through orgasm eventually leads to what is known as sexual impusivity (Hajcak & Garwood, 1988; Barth & Kinder, 1987).

Conclusion

From my own perspective, current attempts at understanding sexual, impulsivity need to, first, correctly define it as a manifestation of impulsivity of control disorder as outlined in DSM III-R (1980) and, secondly, carefully consider the social forces beginning with the early parental influences that develop the anxiety that drives the impulsive behavior. Until helping professionals accurately understand these two primary issues, the ability to design and carry out a suitable therapeutic approach will seriously be impeded.

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