SEXUAL ANOREXIA: A NEW PARADIGM FOR HYPOSEXUAL DESIRE DISORDER

Douglas Weiss
Heart to Heart Counseling Center, Colorado Springs, Colorado, USA

Sexual Anorexia is a relatively new term to the field of sexual addiction. The sexual addict who actively withholds sexual, emotional and spiritual intimacy from their spouse or significant relationship while acting out with themselves or others has been an anomaly for sex addiction treatment providers. This article gives a history of the hyposexual disorder as well as a broadening of the term sexual anorexia and offers a clear diagnostic criteria of sexual anorexia for the sexual addiction treatment provider.

As a field of sex study, sex addiction treatment providers would do well to understand the history and definitions of hyposexual desire as well to view through the lens of the sex therapy field about its characteristics as our field brings a new paradigm to the understanding of this disorder. The birthing of this concept of low sexual desire disorder was in 1980 in the DSM III-R being labeled as inhibited sexual desire disorder. This inhibited sexual desire disorder was defined as “persistent and pervasive inhibition of sexual desire” (American Psychiatric Association, 1980). The primary characteristic of this disorder was subjective distress by either the client or the partner of a client. In 1987 inhibited sexual desire disorder was renamed as Hypoactive Sexual Desire Disorder (APA, 1987). The DSMIV (APA, 1994) defines Hyposexual Disorder as:

Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity; the disturbance causes marked distress or interpersonal difficulty; and the sexual dysfunction both is not better accounted for by another Axis I disorder (except another sexual dysfunction) and is not due exclusively to the direct physiologic effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition.

DSM-IV further classifies hypoactive sexual desire disorder as lifelong (presence of hypoactive sexual desire since the onset of sexual functioning) or acquired (development of hypoactive sexual desire after a period of normal functioning) as well as generalized (loss or absence of sexual desire across all potential situations or partners) or situational (hypoactive sexual desire is limited to certain types of stimulation, situations, or partners).

The broadening of this definition since 1980 is helpful but has its limitations in that it remains to be subjectively measured and “lacking objective, behavioral criteria (Trudel et al, 1996). This concern of the lack of clinical criteria for hyposexual desire is a concern in the sex therapy field (Rosen and Leiblum, 1995).

The estimated rate of men with the Hyposexual Disorder is 15% (Nathan, 1986). The overall estimated rate for Hyposexual Disorder is about 20% (APA, 1987). In the sex therapy field sexual desire disorders are of the most common complaints of couples seeking professional help for sexual issues (Segraves and Segraves, 1991).

The field of sex therapy has been viewing this issue of hyposexual desire for almost 20 years. The various researchers and authors have a wide range of perspective both in conceptualizing Hyposexual Desire as well as treatment recommendations.

The first developer of inhibited sexual desire disorder that later became hyposexual desire was Kaplan (1979). His view of this disorder is that it was a result of intrapsychic anxiety that had two levels. Level 1 was labeled mild,
which included guilt over sexual pleasure. Level 2 was moderate which involved fear of intimacy or a deep anxiety of fear of injury. This pioneer of hyposexual desire developed a three-phase model of sexual response cycle including desire, excitement and orgasm. Separate neurophysiologic pathways (Kaplan 1979) mediated these phases according to Kaplan.

Sexual trauma of an individual has been seen as a contributing factor of those who have hyposexual disorder (Rosen and Leiblum, 1995). In one study that was retrospective of 372 sexual assault survivors close to 85% of these survivors had sexual arousal or desire issues (Becker et al, 1986).

In a male study of those who have hyposexual disorder the sample reported a significantly higher frequency of masturbation compared to the control group (Nutter and Condron, 1985). This may be a helpful fact for those in the treatment of sexual addiction, which often includes a significant masturbation pattern.

The field of sex therapy also looks at hyposexual disorder from a relationship perspective. Fears of intimacy, fear of closeness, fears of commitment and fears of abandonment where brought forth by LoPiccolo and Friedman (1988) as contributors to the hyposexual disorder. They go on to state that: control issues directed toward self or partner; an inability to fuse feelings of love and sexual desire; and unresolved feelings of anger, hatred, and resentment may all play causal roles in creating and maintaining hypoactive sexual desire (LoPiccio and Friedman, 1988)

Trudel (1995) discusses several characteristics that he believes contributes to hyposexual disorder including: “Cognitive distortions related to hypoactive sexual desire could be investigated by identifying rigid, irrational beliefs and unreasonable expectations about sexuality, negative self-talk as a result of early trauma or the effects of a morally strict religious upbringing also require identification.”

Beck (1995) also sites relational factors that can play a major role in Hyposexual Disorder including lack of trust and intimacy, conflicts over power and control and lack of physical attraction. Beck (1995) also mentions other issues that may contribute to low sexual desire in a client that include: depression, grief, chronic pain, sleep deprivation, body image problems, low self esteem, alcohol or substance abuse, chronic mental or physical illness and the taking of certain prescription drugs.

**Treatment Perspectives**

In the assessment phase of hyposexual disorder the clinician is to also assess for other sexual dysfunction’s such as erectile disorders, premature ejaculation as well as inorgasmic functioning according to Trudel, Boulos, and Matte (1993), Heiman, Epps and Ellis (1995) suggest 3 categories of importance in assessing clients with Hyposexual Disorder:

*Individual patterns:* Current and historical, physical health including illness, surgeries and medications; psychological functioning; solo sexual activity such as masturbation and fantasy; gender identity; sexual orientation.

*Interpersonal patterns:* Current and historical relationships; family patterns; sexual relationships.

*Sociocultural patterns:* Current and historical beliefs about sex; gender, sexual orientation; importance of religion.

Beck (1995) as well as Heiman, Epps and Ellis (1995) provide a condensed review of the studies compiled in the field of sex therapy on hyposexual disorder. The findings generally support that a modified Masters and Johnson approach including cognitive behavioral approaches, education, skills, learning, desensitization as well as directive intervention and at home exercises can be measurably helpful in treating hyposexual disorder. The combinations that appeared to be most useful in this review of literature were those who combined the Master and Johnson approach with couple therapy and or additional orgasm consistency training. Trudel (1996) also states that communication skill development is important in the treatment of hyposexual desire.
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Sexual Anorexia: A New Paradigm

This framework of understanding hyposexual desire from the field of sex therapy can lead us now into a broader paradigm of understanding this dynamic and disorder of hyposexual desire in the field of sexual addiction. Heiman, Epps and Ellis state: “The therapist can also offer to the clients new ways of understanding and conceptualizing the problem on any one of the levels. To do this with some success, however, the therapist must find an explanation that fits several levels of the couple’s reality.”

As a clinical and scientific community, we have done well at identifying the issue of sexual addiction. As a professional body it has taken us longer to develop clinical criteria for sexual addiction. The same is true of the issue of sexual anorexia. The beginning of the term sexual anorexia was used in our field in a roundtable discussion at the National Council of Sexual Addiction Researchers in 1992 in Dallas, Texas. The group began to create a language for what as a clinical community we were experiencing in our treatment of sexual addiction.

The fact that there were people outside a committed relationship but that this same person was minimally involved or not involved at all sexually with their committed partner. This pattern of sexual inactivity continued with the primary partner even if the sexual addict was by all appearances in active recovery from sexual addiction. As the years went by and we as a clinical community were experiencing this nationwide, we began to identify a paradigm expansion in our field of sexual addiction, which became identified as sexual anorexia.

Sexual anorexia defined by Carnes (1997) as “Those who could not force themselves to be sexual without dire internal consequences” and “an obsessive state in which the physical, mental and emotional task of avoiding sex dominates ones life”. Weiss (1998) defines sexual anorexia as “The active, almost compulsive withholding of emotional, spiritual and sexual intimacy from the primary partner.” It is the consistent sabotaging of any ongoing intimacy in a marriage or committed relationship.

Carnes and Weiss address the causes of sexual anorexia. In Carnes’ (1997) book Sexual Anorexia: Overcoming sexual self-hatred, he addressed what he calls the personal histories of a sexual anorexic: 1) A probable history of sexual exploitation or severely traumatic sexual rejection, 2) Families of anorexics may present extreme patterns of behavior or thought. 3) A deep influence by a cultural, social or religious group that views sex negatively and supports sexual oppression and repression. Weiss (1998) in the video Sexual Anorexia: Beyond Sexual, Emotional & Spiritual Withholding also identifies three probable causes for sexual anorexia to develop: 1) Sexual abuse, 2) Attachment Disorder with the cross-gender parent and, 3) sexual addiction. The anorexic may present one, two or all three causes for the sexual anorexic behaviors. The issue of sexual abuse covered by Carnes and Weiss is easily understood to relate to sexual anorexia. The emotional, spiritual and physiological trauma connected to ones sexuality can lead to a variety of sexual and interpersonal responses, sexual anorexia being just one a person may choose.

The issue of family of origin can also be understood to contribute to sexual anorexia, as child needs intimacy and nurturing from its primary caregivers. The lack of intimacy or the consistent absence of or the violation of this intimacy can lead a child to associate discomfort pain or at best unfamiliarity with intimacy. Weiss contends that the cross gender parents model of intimacy can be a duplication of how the person expects or desires a cross gender intimate relationship to be in their committed relationships.

The issue of sexual addiction being a causal affect for sexual anorexia must be addressed by the clinician treating sexual addiction. Weiss (1998) contends that the early sexual reinforcement being bonded to the fantasy world (with or without pornography) and being maintained through adulthood can lead a person to primarily sexually bond to the other world. The neurological chemical bonds to the unreal world combined with the psychological ease of a fantasy world can allow a person to conclude the altered state fantasy world is not only easier psychological and sexually but preferred. Once the individual makes this conclusion whether in there 20’s or 50’s the anorexia symptoms will follow.

Carnes(1997) sees the symptom cluster of the sexual anorexic as primarily sexual:

“A dread of sexual pleasure
A morbid and persistent fear of sexual contact
Obsession and hypervigilance around sexual matters
Avoidance of anything connected with sex
Weiss’s conceptual framework of sexual anorexia is more of an intimacy disorder than that of primarily a sexual disorder. This broader paradigm of sexual anorexia demands a broader symptom cluster for clinical assessment and treatment. The following eight behavioral characteristics can be used by both clinicians and partners of the sexual anorexic to determine if treatment is being effective.

1. Withholding love from primary partner. In this facet of sexual anorexia they actively withhold their feelings and behaviors of love from their partner. Partners of anorexics often state not feeling important or loved. Withholding may be only at home with their partner while publicly they may behave affectionately toward their partner.

2. Withholding praise or appreciation from their partner. Withholding praise or appreciation can be done consciously or unconsciously. When presented with this behavioral characteristic most sexual anorexics and their partners will acknowledge the behavior truth of this lack of ongoing, void of praise and appreciation.

3. Controlling by silence or anger. The sexual anorexic that is confronted by life issues to come close to their partner and deal with an issue or feeling will often resist this process vehemently. The two most common dynamics employed is total shut down i.e. leaves, go to another room, watch television avoidance or anger.

4. Ongoing or ungrounded criticism that causes isolation. The anorexic will push away their partner using criticism especially if the are headed toward emotional or sexual intimacy. This can be an ongoing experience for the couple where one partner is sexual anorexic.

5. Withholding sex from the partner. The anorexic will stay in control of the sexual relationship by: refusing to initiate sex, saying no to the sexual advance, makes the partner initiate the majority of sexual advances. Anorexics may also make sexual encounters emotionally void or unpleasant so the partner will not want to have further sexual encounters. This lack of sexual initiative and activity is the clearest symptom to evaluate in the initial intake process.

6. Unwillingness to discuss feelings with partner. The anorexic withholds emotional intimacy. This unwillingness to discuss feelings may be localized to the primary partner or global to all relationships. This withholding is active in the anorexic relationship style and is important for clinical intervention.

7. Staying so busy that the anorexic has little to no relational time for the partner. This busyness may take the form of hobbies, political or religious pursuits, children’s activities or can be as passive as watching television for hours a day. The anorexic rarely initiates long periods of alone time alone only with their partner. i.e. no romantic weekends or vacations without friends and family members.

8. Making any issues in the relationship the partner’s problem before owning any of the issue. Blaming the partner consistently is a characteristic of anorexia. A core motivation of the anorexic is to keep the perfect picture. Apologies for anorexics tend to be slow in coming as well.

If an anorexic is single, they often have patterns of short-term relationships or multiple years without any romantic relationships. Broadening of the low sexual desire issue to a paradigm of relational withholding called sexual anorexia can be helpful in the sexual addiction population. The sex addiction population understand “acting out” and with some education they can understand the above behavioral cues as “acting in.”
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Case Studies

1) A 40 year old male dentist married, a recovering Sex Addict for 6 months, maintaining boundaries of no self sex, or sex outside marriage, and no pornography. This individual was also anorexic with his wife. He was not a sexual abuse survivor but he had no emotional bonding with mother or father. He fit full criteria for an anorexic. He would withhold spiritually, emotionally and sexually. He would be sexual only if she asked and only after she put up a real fight about the sexual deprivation in the relationship, and then withheld his emotional and spiritual self, punishing her during sex. He did a three-day intensive at Heart to Heart Counseling Centers in Fort Worth, Texas. He and she worked together on the behavioral treatment plan together, created a sex system with financial consequences. If he failed to initiate, prayer together, daily feelings, daily praise, He also incorporated the SA sponsor on withholding behavior and used his SA group for recovery with his withholding behavior. The couple was able in a few weeks to start restoring the feelings and discipline of intimacy in their relationship. This couple has maintained sobriety from Anorexia.

2) She was a 37-year-old professional woman in her second marriage. She fit most the criteria for Sexual Anorexia. She would not have sex with her husband who she said she loved, she would not also be emotionally or spiritually intimate with him as well, although she had her own spiritual life. She grew up in an Alcoholic family with some physical abuse by her father. She had no nurturing from father, even until this date he’d give no evidence of wanting a relationship with her. She had a regular masturbation pattern with a fantasy lover since adolescence and identifies herself as a masturbation addict.

3) A single sex male addict and Sexual Anorexic 28 years old and a computer analysts who is in active recovery from Sex Addiction. His boundaries for his recovery is no pornography, no masturbation, no sex outside of a committed relationship. He has not been in a dating relationship for 7 years. He applied the prayer, accountability and feelings work with support system and therapist as well and did daily affirmations listed in the sexual anorexia video by Weiss. His treatment involved initiating to talk and meet woman his age and single. He did this daily. In the process he met a girl he liked and is currently dating her responsibly.

Prevalence

In discussing sexual anorexia in the context of a sex addiction population it behooves us to attempt to estimate the prevalence of sexual anorexia in this population. A sexual anorexia criteria questionnaire was emailed out to approximately 2000 members of a free sex addiction newsletter that is mailed out weekly through www.sexaddict.com. A second sexual anorexia criteria questionnaire was emailed out to approximately 1000 members of a free partners of sex addiction newsletter that is mailed out weekly through www.sexaddict.com. These responses were tallied and compared to each other. To meet criteria for sexual anorexia one had to answer in the affirmative to five of the nine questions on the sexual anorexia criteria questionnaire. The prevalence of sexual addicts, male and female and the partners of sex addicts that were all females (three men did fill out partners questionnaire but this was not a large enough sample) that met criteria for sexual anorexia are listed in table 1. A list of the questions and the percentages that were answered in the affirmative per population group are listed in table 2.

| Table 1 |
| Met criteria for sexual anorexia |
| (5 or more positive answers) |

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Sex Addicts (males)</td>
<td>29%</td>
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<tr>
<td>Sex Addicts (females)</td>
<td>40%</td>
</tr>
<tr>
<td>Partners of sex addicts (female)</td>
<td>39%</td>
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Table 2

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<tr>
<th>Sexual Anorexia Criteria Questionaire</th>
<th>Percentages that answer questions yes</th>
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<tbody>
<tr>
<td>Do you withhold love from your partner/spouse ?</td>
<td>MALE/SA 24%   FEM/SA 38%   PARTNERS 37%</td>
</tr>
<tr>
<td>Do you withhold praise or appreciation from your partner/spouse ?</td>
<td>33% 42% 37%</td>
</tr>
<tr>
<td>Do you control by silence or anger in your primary relationship ?</td>
<td>70% 67% 58%</td>
</tr>
<tr>
<td>Do you have ungrounded or ongoing criticism that causes isolation in your primary relationship ?</td>
<td>41% 46% 51%</td>
</tr>
<tr>
<td>Do you withhold sex from your partner/spouse ?</td>
<td>26% 42% 37%</td>
</tr>
<tr>
<td>Are you generally unwilling to discuss your feelings with your spouse or partner ?</td>
<td>45% 42% 27%</td>
</tr>
<tr>
<td>Do you stay so busy so that you have little to no relational time for your partner/spouse ?</td>
<td>33% 29% 41%</td>
</tr>
<tr>
<td>When there are issues in the relationship do you tend to make them your partners fault first before accepting responsibility ?</td>
<td>38% 54% 56%</td>
</tr>
<tr>
<td>Do you control or shame your partner/spouse around money issues ?</td>
<td>20% 33% 28%</td>
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Behavioral Strategies

1) Praying together: The couple regardless of what the spiritual belief contract to pray out loud with each other. These minutes of prayer a day is designed to open and connect the spirituality of the couple thus avoid spiritual withholding.
2) Reading Recovery literature: To date Carnes book is the only book to read on this issue or Weiss’ Sexual Anorexia video can also be of help here. Other readings on intimacy, communication, or 12 Step Recovery can supplement this reading. This is to keep the anorexia in an active awareness and growth in the areas of intimacy and recovery.
3) Feelings: The couple does a daily structural feeling communication exercise with the boundaries of 1) No feeling example can be about the other person or the relationship.2) maintain eye contact during the communication of feelings.3) no feedback about the feeling shared. For more see Weiss’ 101 Practical Exercises for sexual addiction or The Final Freedom. This sharing of feelings is daily and keeps the emotional dimension of the relationship open and in a growth pattern.
4) Praise: Once the couple is instructed on giving and receiving praise (eye contact, saying thanks when they let praise in). They add this to their daily living disciplines. This allows the anorexic to initiate praise. This exercise is a minimum of one daily.
5) Phone Calls: The anorexic finds an accountability person of the same gender to check in daily about the withholding behaviors. If the anorexic is already in a 12-step sex or other type of support group this sponsor can work in this accountability. This accountability should be daily for the first 100 days then more to what is needed for accountability to still be wanted.
6) Meetings: There are no sexual anorexic 12-step groups yet developed. Many who are seeking help from this area are also seeking help from sex addiction. Recovery clients will probably be attending an S group of some kind and or a therapy group. If they attend an S group they can add “no withholding behavior” with my partner to their recovery boundaries or bottom line behavior so as to have group awareness of their progress of being sexually sober from sexual anorexia.

7) Affirmations: The anorexic gets into a relaxed state and reads aloud the list of affirmations in the sexual anorexic workbook from the sexual anorexia video by Weiss. These affirmations have to do with accepting their sexuality, so that they can initiate love and intimacy etc. These are done daily for 1 year. This is an important part of the anorexia treatment. The core belief of the anorexia can be challenged by the ongoing repetition of these affirmations.

The paradigm of sexual anorexia being broadened to a relational withholding can facilitate a behavioral treatment. Weiss (1998) has listed such a treatment including: “praying together daily, daily structured feeling communication, agreeing to a sex system, accountability to a sponsor person for anorexic behaviors, daily structured affirmations and utilization of the recovery persons current support group through the recovery process.

Hypoactive Desire Disorder has developed in the last 20 years primarily in one discipline of study. As we absorb this population that exists in the sexual addiction population that we already identify and treat, it behooves our field to further examine, define this disorder in behavioral paradigms as well as produce treatment protocols.

As a field of study the next step is for us to develop experiments that challenge our protocols of treatment of sexual anorexia, as well as identify the size of the anorexia population within the sexual addiction population. This next frontier of our field is full of learning and growing opportunities for all may we rise to the challenge of this frontier.

REFERENCES


