

Sexual Addiction and ADHD: Is There A Connection?

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Sexual addiction does not exist in isolation. As with most addictions, there can be co-occurring disorders. This study was conducted to investigate whether or not there is a connection between sexual addiction and attention deficit hyperactivity disorder (ADHD). This article will discuss the results of the study as well as the limitations of the instruments used. The importance of trauma model treatment with sexual addiction and ADHD will be considered. The need for further research will also be addressed. The term ADHD will be used throughout the article except where specific quotes use other terminology. The DSM-IV uses the term Attention Deficit/Hyperactivity Disorder and identifies a combined type, a predominantly inattentive type and a predominantly hyperactive type.

“Jim” is a man in his 22nd year of marriage. During this time he has acted out sexually with a number of affair partners. Jim has a family history of substance abuse and addiction. When he was arrested for sexually acting out in public he sought treatment for his sexual addiction. Behavioral approaches to the treatment of Jim’s sexual addiction were ineffective. During the course of treatment it was discovered that Jim had attention deficit hyperactivity disorder with predominantly inattentive symptoms. Jim was sent to a psychiatrist for a medical evaluation. The psychiatrist placed Jim on a psychostimulant medication. Therapy for both sexual addiction and ADHD continued. Jim is now 8 years sober from his sexual addiction. He had his wife have renewed their wedding vows and continue to do well in recovery.

Addictions often mediate a variety of disorders. Substance abuse may be the attempt of an individual to cope with depression, bipolar disorder, anxiety disorders and other disorders identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, TR). The connection between

ADHD and addiction has been well documented (Martin dale, 1995; International Medical News Group, 1998; Whiteman & Novotni, 1995; Amen, 2001). ADHD children and adults are likely to engage in some form of substance abuse. "It is common for people with ADHD to turn to addictive substances such as alcohol, marijuana, heroin, prescription tranquilizers, pain medication, nicotine, caffeine, sugar, cocaine and street amphetamines in attempts to soothe their restless brains and bodies. Using substances to improve our abilities, help us feel better, or decrease and numb our feelings is called self-medicating." (Richardson, 1997; Whalen, Jamner, Henker, Delfino, & Lozano, 2002; Lambert & Hartsough, 1998).

We believe that the treatment of ADHD and other underlying disorders, when present, is essential in the effective treatment of addictive disorders. We also believe that various forms of trauma are possible etiologic factors in the development of sexual addiction. In this article we will present the results of a very preliminary study that we conducted to investigate a possible correlation between ADHD and sexual addiction. In the same study we also explored the presence of various forms of trauma reactions. One of our beliefs has been that trauma could also be a factor in the development of various forms of brain dysfunctions including ADHD.

SEXUAL ADDICTION AND ADHD

We know many therapists who specialize in the treatment of sexual addiction who have anecdotally reported to us that their clients have a high incidence of ADHD. However, while some literature has reported a relationship between ADHD and a wide variety of chemical addictions, no mention of sexual addiction has been located to date. No research has been reported in the literature on the relationship of sexual addiction and ADHD.

There are similarities in some characteristics of sexual addicts and people who live with ADHD. Both groups of people, for example, report difficulty tolerating boredom. There is a tendency in both populations toward high-risk behavior. Both groups seem to have stimulus seeking brains. Both groups may have difficulty in calming the brain and controlling mood. An informal survey of practitioners conducted by Richard Blankenship identified sexual acting out as the ultimate in mood control for the ADHD person. The clandestine nature of some forms of sexual acting out can create the adrenaline rush to elevate mood. The release of chemicals during orgasm can calm the brain and bring the mood down into a state of relaxation.

SEXUAL ADDICTION AND TRAUMA

The incidence of trauma in sexual addicts has been well documented. Research has shown that 97% of sexual addicts have been emotionally abused

as children, 72% were physically abused, and 81% were sexually abused (Carnes, 1991). Trauma treatment of the sexual addict can identify what the addict is medicating with his/her addiction.

Individuals who buy into the illusion that some form of sexual fantasy or acting out will address their wounds can begin to develop qualities of a sexual addict. Sexual fantasy and acting out imprints itself on the individual as a comforting solution. Without treatment of these core trauma wounds the sexual addict will either become a “dry drunk,” relapse, or find another addiction to cope with their trauma. Addictions can be an attempt to cope with or resolve a problem either by raising or lowering moods or by finding the false solution to the trauma wound.

Sex addicts who are able to address the trauma issues in their history appear to be more likely to achieve long term sobriety. Traditional behavioral approaches to addiction treatment have yielded poor results. Some studies have documented their success rate as low as 2–3%. Trauma model treatment does not mean that the addict will never struggle again. It does take away some of the craving and makes the addiction more manageable. If the needs can be met in a legitimate way the need for addictive medication is minimized. Treating trauma will help take away some of the struggle and will greatly assist addicts in their journey towards sobriety and healing.

As addicts deal with trauma, a variety of other disorders may be discovered. Some have been predisposed through family history, genetics, environment, injury, and brain structure to disorders found in the DSM-IV TR. Issues such as ADHD, panic attacks, generalized anxiety, obsessive compulsive disorder, post traumatic stress, dysthymia, major depression, and bipolar disorder may have a significant impact upon the speed and quality of the addict’s recovery. Treatment of each these conditions can greatly assist the addict in recovery. When the conditions running alongside sexual addiction are treated the addict will have more ability to focus on trauma resolution, family relationships, personal development and self care, and their recovery and sobriety.

The focus of this study involves the relationship between sexual addiction and ADHD. The inability to focus will impact the ability to function in families and other interpersonal relationships. Job performance is improved with treatment of ADHD. Marriage and parenting relationships improve when ADHD is treated. As the addict begins to address issues of sexual addiction and trauma, we believe that treatment of ADHD may help them do better in therapeutic settings. As an addict seeks to break the cycle of addiction, a thorough understanding of co-occurring disorders may help in early recognition and prevention of problems in children. If an addict is ADHD there is a high probability that their child may be predisposed to ADHD (Hynd, 1991; Barkley, 1998). An understanding and treatment of these conditions may assist the addict in keeping the cycle of addiction from passing on to another generation.

ADHD AND TRAUMA

It is historically unfortunate that the treatment of ADHD and the treatment of addiction have the absence of effective trauma treatment in common. From observation, therapists are failing to take the trauma histories of ADHD patients seriously. Research, however, consistently suggests that a multi-modal approach is needed in treating ADHD (Richardson, 1997; Aust, 1994; Quinn, 1995). In spite of a plethora of research suggesting the need for trauma model treatment, therapists persist in treating only behavioral and medical aspects of ADHD.

Consider the damage done in families by the school system and by peers before ADHD is ever diagnosed. Uneducated parents may emotionally and physically abuse ADHD children before they have been diagnosed. ADHD children can be asked to perform functions in chaotic environments that their brains are incapable of handling. The school system may label ADHD children as troublemakers, daydreamers, and behavior problems. Peers may become frustrated with the social problems of the ADHD child and may subject them to teasing and other forms of humiliation (Dumas, 1998). Although many ADHD children are intelligent and creative, innovative ideas may be discouraged and creativity squelched. By the time the child reaches adult years they may have been discouraged from pursuing goals and dreams. (Whiteman & Novotni, 1995). The sense of inferiority, frustration, and negative labeling all underscore the need for trauma treatment of ADHD.

From observation, it appears that the majority of ADHD treatment is limited to medication management and behavioral techniques. Treatment of ADHD has mirrored traditional addiction treatment in that it has been focused primarily on treating symptoms and managing behavior. Trauma counseling needs to be considered in the treatment of the ADHD adult. When an individual goes through life with untreated ADHD, poor self-esteem and a pattern of learned helplessness are common (Whiteman & Novotni, 1995). Individuals who are not diagnosed until adult years report that they were subject to bullying, ridicule, punishment, and isolation as children. 92% of adults diagnosed with ADHD after age 18 said that they wish they had been diagnosed and treated as children (Richwood, 2000). The impulsive nature of ADHD may create crises that can become a double-edged sword. The desire for stimulation may lead to destructive decisions that create personal and legal crises. The fighting, teasing, difficulties with social interaction, and the tendency to talk without thinking may create problems with healthy functioning. ADHD children carry negative thoughts into adult years. A brain burdened with negative thoughts will have difficulty learning and processing information. It may also impact physical health (Amen, 2001). The psychological aspect of untreated ADHD must be addressed in the recovery process of treating adult ADHD. To fail to treat trauma is to fail to treat ADHD.

ADHD AND ADDICTION

People with ADHD will medicate their symptoms in some form. Medical treatment will be discussed later. If ADHD is undiagnosed and treated and if symptoms persist the individual will often turn to addictive substances and behaviors to medicate their pain. Amen (2001) documents that people with ADHD have tendencies toward food, alcohol, drugs, and work addictions. Whiteman and Novotni (1995) point out that ADHD is associated with addictions. Hallowell and Ratey (1995) estimate that 30–50% of Americans suffering from ADHD are using drugs and alcohol to self-medicate ADHD symptoms. Erick Mick (1998) found that adult ADHD increases the risk of substance use disorders and worsens their course. Mick found that adults with ADHD were more likely to move from alcohol to drug use. These same people were less likely to experience remission of symptoms.

Adults with ADHD were five times more likely to move from substance dependence to abuse. One study of 239 adults with ADHD revealed that it took a median of 4 years longer (7 years to 3 years) for substance use disorder to remit in ADHD patients. Some turn to stimulants such as cocaine and methamphetamine for relief from symptoms. Many have self-medicated symptoms with drugs like caffeine, nicotine, diet pills, and speed. These drugs have given ADHD people more of an ability to control their brains.

The drug of choice for ADHD people in several studies was marijuana as opposed to cocaine and other stimulants. (Mick, 1998). The brain may feel that it cannot shut down. Clients with ADHD report feeling that their brains are working from the time they get up in the morning until they go to bed at night. Stimulants like caffeine and speed may work on the brain in ways that mirror psychostimulants such as Ritalin or Adderall. Marijuana seems to be the drug of choice for calming the brain. The use of illegal and destructive medications is like pouring gasoline on a fire (Richardson, 1997).

Amen (2001) believes that the type of drug being abused may depend upon the type of ADHD with which the individual is coping. Those with “classic” ADHD (both inattentive subtype and with hyperactivity) will tend to abuse stimulants such as methamphetamine and cocaine. People with anterior cingulate (overfocused) ADHD tend to abuse alcohol. Those with ADHD that affects the limbic system and the basal ganglia tend to use a combination of marijuana and stimulants while people with temporal lobe abuse alcohol and marijuana.

It is not enough to treat addictions and ignore the ADHD that the individual may be medicating with the addictive substance. Diagnosing and treating both conditions greatly improves the individual’s chances of recovery. The recovering substance abuser may have a difficult time taking medication to treat ADHD. These fears must be addressed in a professional setting. Untreated ADHD can be a significant factor in addiction relapse. Suppose a client spends years in therapy and treatment of substance addiction, yet continues

to lose jobs, marriages, and damages relationships. Untreated ADHD can significantly impact recovery from any addiction (Richardson, 1997).

ADHD if left untreated will metastasize into other disorders. ADHD untreated has been known to become conduct disorder in adolescence and antisocial personality disorder in adult years (Gresham, Lane, & Lambros, 2000). Left untreated, ADHD can also develop into substance and behavioral addictions. A Utah study revealed that 24% of male inmates had ADHD. Other studies have shown that up to 40% of people in minimum security prisons have disorders on the ADHD spectrum (McCallon, 1998). Perhaps no study has revealed the magnitude of treating ADHD along with co-occurring disorders than that of Dr. Paul Wender. Wender was establishing through his study that ADHD is a lifelong condition and people do not outgrow it. In this study, when inmates were paroled they entered a program for a period of 6 months to 2 years. They were given medication and placed under the care of counselors, doctors, and support groups. National recidivism rates for people released from prison are approximately 60%. The inmates in this study had a two year recidivism rate of only 10%. Only one individual in the study had a new criminal charge while a few had parole violations. Many of these men had been diagnosed as children with ADHD but treatment did not continue past grade school years. Some were told that they would outgrow ADHD after the teen years. None were being treated into their 20's. 18% had discovered crystal meth from the meth labs that now exist in abundance. The methamphetamine had given them the ability to remain calm and focused. 20% were medicating with marijuana and heroin. More severe discipline will not change ADHD. The guilt and shame families feel as they visit relatives in prison is incredible. Way too many were advised by people in the school system, counseling, and psychiatry that ADHD was a condition they would outgrow. Or, in the words of Dr. McCallon, medical director in the Colorado department of corrections "if he outgrew it, what is he doing in my prison?"

In summary, sex addicts and people with ADHD have several things in common.

1. Given the amount of data linking ADHD and addiction, it seems only reasonable to consider a connection between ADHD and sexual addiction. To date, no studies were located on the relationship between ADHD and sexual addiction. Sex addicts and adults with ADHD are both trauma survivors
2. Sex addicts and adults with ADHD typically have stimulus seeking brains
3. Sex addicts and adults with ADHD do not tolerate boredom
4. Sex addicts and adults with ADHD have a tendency toward high risk behavior
5. Both sexual addiction and ADHD have neurochemical issues that contain implications for treatment

Medical intervention for ADHD can benefit the recovering addict with neurochemical aspects of ADHD and sexual addiction (Ballard, Bolan, Burton,

Snyder, Pasterczyk-Seabolt, & Martin, 1997; Forness, Kavale, & Crenshaw, 1999). Like people with ADHD, sexual addicts experience different forms of abuse, grow up feeling inferior, have self-esteem issues, feel disconnected emotionally, have intimacy issues, cope with squelched creativity, constant frustration and out of control behavior. The brain of the sex addict seeks stimulation. The ADHD brain seeks high risk behaviors and has difficulty tolerating boredom. People who have ADHD seek relief from the symptoms created from trauma. Sexual addicts seek relief from the symptoms of emotional, physical, and sexual abuse. Both can benefit from trauma model treatment.

Sexual addicts often report some level of relief from symptoms of acting out when co-occurring disorders such as ADHD are being treated. The use of these instruments assisted the workshop staff in treatment recommendations. Many are reporting some level of relief from sexual addiction symptoms when ADHD and other disorders are also treated. When the ability to focus and concentrate returns, addicts seem to be more able to stick with the hard work of recovery and transformation.

We felt that these factors deserve further research to consider the correlation of sex addiction and ADHD.

THE STUDY

Seventy-two participants were surveyed from a treatment program for sexual addiction. All participants were given three instruments. The Sexual Addiction Screening Test (SAST) was given to determine who would qualify for the study. Participants who had a score of 13 or higher were selected. The clinical observation of the treatment staff was also considered in selection. The AMEN brain system checklist was also administered as an instrument to determine the presentation of ADHD. The Carnes Trauma Reactions Index was given to determine types of trauma that might exist. It should be noted that these instruments are not without limitations. The Sexual Addiction Screening Test (SAST) and the Carnes Trauma Reactions Index have not been validated in scientific study. The AMEN brain system checklist is a self-report instrument designed to assess the possible existence of ADHD and its presentation. It has been corroborated with the results from nearly 20,000 SPEC scan studies that Dr. Amen has conducted, but it has yet to be validated by independent research. The first 9 items of the checklist do correspond directly to the DSM-IV TR criteria for ADHD.

RESULTS

Sexual Addiction Screening Test (SAST)

Of the 72 men surveyed, 70 qualified for the study with a minimum score of 13 on the Sexual Addiction Screening Test (SAST). Of these 70 men only 9

had scores between 13 and 18. The other 61 participants were at least 19 and above. The average score of these participants was 19.99. By the scores on the SAST and the observation of the clinical staff all participants were dealing with sexual addiction issues.

Amen Brain System Checklist

The Amen Brain System Checklist considers symptoms related to functioning in the prefrontal cortex (PFC), anterior cingulate, limbic system, basal ganglia, and the temporal lobe. The prefrontal cortex is most often connected to classic attention deficit hyperactivity disorder as described in the DSM-IV, TR (Amen, Roberts, & Pennington, 1998). Questions 1–18 assess the predominantly inattentive type of ADHD without the hyperactivity. Questions 19–28 assess the hyperactivity or combined type of ADHD. According to the Amen screen, a score of at least 4 in each area means that ADHD is possible, 6 or more means that it is probable, and 8 or more means that it is highly probable. The average score for this group was a 6.5. 14% scored in the possible category, 21% were in the probable category, while 34% were highly probable. Out of 70 participants 47 (67%) reported some level of classic ADHD. Only 13 participants (19%) had scores indicative of ADHD on questions 19–28. The average score on questions 19–28 was 1.93. The majority of the men surveyed report the predominantly inattentive type of ADHD.

The anterior cingulate (AC), limbic system (LS), and basal ganglia (BGS) scores break down as follows. A score of 4 means that AC hyperactivity is possible, 7 or more means that it is probable, while 10 and higher means highly probable. The anterior cingulate deals primarily with symptoms of obsessive compulsive disorder (OCD). Questions 29–45 assess AC hyperactivity. The average score in this section was 4.44. 22 participants (31%) reported possible AC hyperactivity, 5 (7%) reported probable scores and 8 (11%) were in the highly probable category. 35 participants out of 70 (50%) report some level of anterior cingulate hyperactivity.

The limbic system questions assess mood issues such as depression. Questions 46–63 assess depression and mood issues. The average score on the LS was 5.51. 12 (17%) reported possible LS hyperactivity, 14 (20%) reported probable LS hyperactivity, while 15 (21%) reported highly probable LS hyperactivity. 41 of the 70 participants (59%) report some level of LS hyperactivity.

The basal ganglia (BGS) assesses anxiety issues such as panic, generalized anxiety, and post traumatic stress in questions 64–88. An average score of 5.14 again reveals levels of BGS hyperactivity. 18 (26%) reported possible BGS hyperactivity, 10 (14%) reported probable levels of BGS hyperactivity while 4 (5%) reported highly probable BGS hyperactivity. 36 participants (51%) report some level of BGS hyperactivity.

The breakdown on the temporal lobe system hyperactivity (TLS) is the same as classic ADHD. Questions 89–101 assess symptoms related to anger and bipolar disorder. 4 means possible temporal lobe system hyperactivity, 6 means probable, and 8 means highly probable. The average score on these questions was 1.77. Four participants (5%) reported possible TLS hyperactivity. 1 (1%) reported probable TLS hyperactivity while 4 (5%) reported highly probable TLS hyperactivity. Nine participants (13%) report some level of TLS hyperactivity.

Carnes Trauma Index

The Carnes Trauma Index (CTI) assesses different types of trauma reactions across the lifespan. Scores of 6 or higher in each category are considered significant. Trauma reactions (TRT) are current reactions to trauma events in the past. The average score of participants was 5.83, with 30 participants (43%) reporting TRT scores of 6 or higher. Trauma repetition (TR) are repeating situations or behaviors that parallel early trauma experiences. The average score of participants was 5.94, with 32 participants (46%) reporting scores of 6 or higher. Trauma Bonds (TBD) involve being connected to people who are shaming, dangerous, and exploitive. The average score of participants was 4.63, with 23 participants (33%) reporting scores of 6 or higher. Trauma shame (TS) refers to feeling unworthy and having self-hate due to trauma experience. The average score was 7.60, with 48 participants (69%) reporting scores of 6 or higher. Trauma pleasure (TP) refers to finding pleasure in the presence of extreme risk, violence, danger, or shame. The average score was 6.03 with 35 participants (50%) reporting scores of 6 or higher. Trauma blocking (TB) refers to a pattern of numbing, blocking out, or overwhelming feelings that come from trauma. The average score was 7.47, with 50 (71%) participants reporting scores of 6 or higher. Trauma splitting (TS) involves ignoring the realities of trauma by disassociating or “splitting” off experience of parts of self. The average score was 9.01, with 58 participants (83%) reporting scores of 6 or higher. Trauma abstinence (TA) refers to depriving oneself of necessary things because of traumatic acts. The average score was 4.19, with 20 participants (29%) reporting scores of 6 or higher.

Some forms of sexual abuse that the men in this study reported were inappropriate sexual touch and penetration of the genital area, sexual misinformation, and being shamed for asking questions about sexuality. Failure to understand intimacy due to lack of modeling was prevalent and a lack of healthy and accurate information about sexual issues was present in the participants. Cultural trauma of sexual invasion is becoming a factor in sexual addiction. The invasive nature of sexual stimulation in the United States exposes people to sexual arousal at age inappropriate times. The

flood of sexually arousing material in the media engulfs the culture with pictures, innuendo, and a growing level of explicitness that exacerbates sexual addiction.

Physical abuse was prevalent in the men in this study. Many reported various forms of violent assaults upon their bodies. This took the form of hitting (both with hands and objects), pushing and shoving, and “spankings” during times of anger with foreign objects such as belts or paddles. Physical neglect was also reported. Parents failing to model healthy touch and intimacy were reported by male sexual addicts.

Emotional abuse in this population takes the form of yelling, screaming, ridicule, shame, and incest. The emotional incest syndrome is prevalent in sexual addicts. The addict experiences emotional incest when a parent or significant authority figure enmeshes themselves in inappropriate ways with a child. Adams (1991) documents the phenomenon of covert incest. Some children have been used to meet the needs of a parent and, as a result, were unable to go through healthy developmental stages. When these children reach adult years they report difficulty breaking free from families to leave home and pursue normal educational and career objectives. They may have difficulty establishing relationships with the opposite sex if there is an emotional marriage to a parent. The exposure to pornography and other forms of sexual activity during a relationship like this may increase the illusion that sexual acting out will meet the core needs of the individual. Emotional abuse may also take the form of neglecting basic needs. The need to be heard and validated. Failure to listen, minimizing the child’s concerns, failure to provide appropriate care and nurture, and a lack of affection will also leave a child feeling wounded.

Spiritual abuse is being reported by men who experience sexual addiction. There are no percentages available due to lack of research on this issue. Clinical observation indicates that male sexual addicts have experienced spiritual abuse. Sex addicts report negative messages about sexuality with religious connotations. Through silence or direct teaching, the message is sent that sexuality is a subject full of shame. The image the addict has of God may be a projection of issues with a parental figure. Angry and punitive messages about God are reported by sex addicts in this study. Detaching emotionally through religious practice may have left the addict feeling abandoned and neglected. Black and white simplistic thinking, the inability to think for oneself, and the manipulative use of scripture and references to God may cause the individual to feel enmeshed in an empty religious system that fails to model and develop healthy spirituality and spiritual disciplines. Spiritual abuse may impact the addict’s ability to differentiate themselves from the family system. If the message is continually being sent that God would be displeased with them for exploring and using their uniqueness as an individual, then it may be difficult to see themselves outside of the context of an unhealthy family of origin.

DISCUSSION

Given the trauma history of people with sexual addiction and ADHD, it is significant that this population would also report average scores higher than 6 on 4 different trauma scales. Trauma splitting, trauma pleasure, trauma blocking, and trauma shame all revealed scores of 6 or higher by over 50% of the participants. The scores on the Amen brain system checklist reveal different presentations of ADHD in the population being surveyed. 50% report anterior cingulate, 59% limbic system, and 51% basal ganglia hyperactivity in conjunction with prefrontal cortex activity. It is possible that elevated scores in the limbic system and basal ganglia could be situational. Many workshop participants had just experienced their addiction being discovered by a family member or employer and were facing uncertainty in their marriages, families, and jobs. The men in this study exceeded the cutoff score on the SAST by 6.99 percentage points. Based on these scores and the observation of the staff these were clearly men who were dealing with sexually addictive behavior. Our thesis is that treating co-occurring conditions such as trauma reactions, ADHD, OCD, depression, and anxiety will improve the success of recovery from sexual addiction.

The high percentage of people in this study testing positive for different forms of ADHD suggests that there is a possible link between untreated ADHD and sexual addiction. This is preliminary research and would need to be validated with properly structured scientific studies. Depression, anxiety, and obsessive compulsive disorder should also be considered as co-occurring conditions. Case studies presented illustrate the increased potential for improving recovery from sexual addiction if the co-occurring conditions are treated. The impact of trauma needs to be considered in the treatment of both ADHD and sexual addiction. Treatment of co-occurring disorders does not guarantee the elimination of addictive behavior. Indications are that treating ADHD along with sexual addiction will greatly assist the sex addict in their journey of recovery.

ADHD needs to be treated from a trauma model, even without the existence of sexual addiction. Practical treatment of ADHD trauma may involve things like making amends with a child. Before ADHD is diagnosed the level of frustration for a parent is extremely high. A child may have had expectations placed upon them that they were incapable of meeting. A parent acknowledging their mistakes and making apologies can be validating to the child. Reassuring the child that the problem was not a character defect and that there are neurochemical reasons for their difficulties. An age appropriate explanation of neurochemistry can demonstrate to the child that the reasons for their difficulty are not a result of character problems or a negative identity. Openly acknowledging that school work difficulties involve more than "failing to stay on task." Working with the school system to structure an environment conducive to learning will help in rebuilding self-esteem. (Schlozman

& Schlozman, 2000; Carbone, 2001; Reid & Maag, 1998). Beginning to encourage creativity and ingenuity of the child can help develop their sense of uniqueness and validate that they are gifted. ADHD children are typically intelligent and creative (Leroux & Levitt-Perlman, 2000; Turk & Campbell, 2003; Schirduan, Case, & Faryniarz, 2002). The more these gifts can be utilized the more likely people are to develop healthy self-esteem.

While neurochemistry is a clear factor in ADHD, it is important that the child and not the medication be given the credit for their work. Praise the child and not the drug. Medication may make change possible, but in reality the changes come when the child's own strengths and gifts are able to come out from the fog of confusion and anxiety. Medication is a necessary tool in ADHD treatment. But without the intelligence and gifts of the child, it will be ineffective in treating ADHD.

Treating the sexual trauma of cultural and direct invasion must be a part of sexual addiction therapy. The reality of cultural sexual trauma is evident in society. As sexual stimulation has become a routine part of life in America the impact on sexual addiction will continue to be profound. Age appropriate sexuality education will need to be provided at all developmental stages. (Laaser, 1999). Families may have a "don't talk" rule around sexual matters. This can lead to unhealthy levels of curiosity and obsession. Breaking the "don't talk" rule can help alleviate the obsession created by cultural trauma (Ferree, 2002).

CONCLUSION

Our research indicates that there is a possible correlation between men suffering from sexual addiction and ADHD. This research is preliminary and will need further work. Much more research using valid instruments will be needed. Our research raises the question of whether or not the presence of early life trauma could be a factor in both sexual addiction and ADHD. Brain imaging may be a part of the assessment process, especially in cases that are difficult to diagnose. Sex addicts who suffer with ADHD will need effective medical assessment and treatment of it. Sex addicts with ADHD will also need effective treatment of early life trauma. Without medical and trauma treatment, sex addicts will be unlikely to achieve or maintain sobriety.

Only male sexual addicts were evaluated in this study. Female addicts need to be evaluated as well. Long-term studies on the efficacy of treatment need to be conducted. The impact of sexual addiction and ADHD on families needs to be considered. ADHD children of sexually addicted parents need to be observed to see if they have tendencies toward sexual addiction versus ADHD children of non-sexually addicted parents. Trauma in the sex addict and the ADHD child or adult must be treated or you will not heal the wounded heart and spirit of the person.

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