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Hypersexual Disorder: Searching for Clarity

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The conceptualization of Hypersexual Disorder that was proposed for DSM-5 is reviewed and found to be inconsistent with the existing data. Any proposal for adding a new psychiatric disorder should demonstrate the need for a new diagnosis, describe individuals with only that psychiatric disorder, and explain why existing diagnoses are inadequate to describe the new entity. The conceptualization and diagnostic criteria should distinguish between those with the disorder from those without it, as well as demonstrate that the disorder is not a symptom or result of another psychiatric disorder. The current proposal falls short of all these goals. The problems and dangers of adding Hypersexual Disorder to our diagnostic classification system are discussed.

There are individuals who seek mental health treatment because they (or sometimes those close to them) perceive their sexual fantasies, urges, or behaviors to be “out of control.” At present there is no consensus on how to conceptualize these individuals or even how to label their problem. Proposed diagnoses include Compulsive Sexual Behavior (Coleman, 1991), Dysregulated Sexuality (Winters, Christoff, & Gorzalka, 2010), Hypersexual Disorder (Kafka, 2010), Impulsive/Compulsive Sexual Behavior (Coleman, 2011; Raymond, Coleman, & Miner, 2003), Paraphilia Related Disorder (Kafka & Hennen, 2002), Sexual Addiction (Carnes, 1983), and Sexual Impulsivity (Barth & Kinder, 1987). All of these labels have been criticized (see Joannides, 2012; Ley, 2012; Moser, 2011a) and none have gained general acceptance. Nevertheless, Hypersexual Disorder (HD; Kafka, 2010) was considered for inclusion in the forthcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), to be published by the American Psychiatric Association (APA).

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The current critique will focus on Kafka's (2010) HD proposal and expand on my previous criticisms (see Moser, 2011a). The present article will argue that Kafka's (2010) conceptualization of Hypersexual Disorder is inconsistent with Kafka's (2010) own data and proposed diagnostic criteria; the data do not distinguish HD from other existing diagnostic concepts; the diagnostic criteria do not distinguish those with the disorder from those without; "hypersexual" is a misnomer that does not describe the individuals who are likely to be labeled with this diagnosis; and the potential for misuse far outweighs any benefit of including it in a diagnostic manual.

There are individuals who perceive their sexual behavior "as out of control" and there is no dispute that some of these individuals could benefit from psychiatric intervention. Nonetheless, the individual's perception of the problem may not be an accurate assessment or the "problem" may not be an actual problem. Appropriate clinical evaluation may demonstrate that their sexual behavior is a symptom or a result of another disorder (which should become the focus of treatment rather than their sexual behavior) or that the individual's behavior is within normal limits. Even if the Kafka criteria reliably identified these individuals in treatment-seeking populations (see Reid et al., 2012), it is not clear that those attributes are the correct psychiatric parameters on which to make the diagnosis. The conceptualization of "Hypersexuality" as a disorder risks obscuring other primary diagnoses and pathologizing normal variants.

THE CONCEPTUALIZATION OF HYPERSEXUAL DISORDER

Kafka states, "Hypersexual Disorder is conceptualized as primarily a non-paraphilic sexual desire disorder with an impulsivity component" (2010, p. 377). He further characterized HD as "a sexual desire disorders [sic] characterized by an increased frequency and intensity of sexually motivated fantasies, arousal, urges, and enacted behavior in association with an impulsivity component—a maladaptive behavioral response with adverse consequences" (2010, p. 385). Kafka's "definition for Hypersexual Disorder was specifically derived to include elements of . . . both Hypoactive Sexual Desire Disorder and the Paraphilias" (2010, p. 379). I will start by considering the elements of the Kafka's conceptualization.

Is it Impulsive?

Impulsivity is not mentioned or included in the diagnostic criteria for Hypoactive Sexual Desire Disorder, the Paraphilias, or Hypersexual Disorder. According to *Stedman's Medical Dictionary*, an impulse is a "sudden, often unreasoning, determination to perform some act" and impulsive implies the

act is not “controlled by reason or careful deliberation” (1995, p. 860). Even though individuals may feel their sexual behavior is out of control, this does not imply that their behavior is impulsive. Anecdotally, many of these individuals are quite deliberate in how they pursue their sexual activity, their actions have a clear rationale, and there is no evidence that the desire and behavior are so sudden that individuals are unable to postpone the act temporarily until a more appropriate time or place. These individuals can hide the behavior from those who would judge them, often successfully. Their perceived inability to control or reduce the fantasies, urges, and behaviors may be ego dystonic, but it does not suggest the impulse is either sudden or unreasoned. The association of impulsivity with “hypersexuality” has been based on self-report measures. The lack of any objective assessment of whether impulse control is actually compromised in the wake of a sexual cue is absent (Reid, Garos, & Carpenter, 2011). If Kafka means something else by impulsive, he needs to define his terms clearly and carefully.

Kafka and Krueger (2011) suggest that the “hypersexuality” in response to dysphoric affect, stress, and the disregard of the inherent risks of the behavior are signs of impulsivity. Everyone experiences dysphoric moods and stress at times and most use a variety of techniques to mitigate these emotional states (McRae et al., 2010). It is usually the lack of a response or a repeated ineffective response that signifies a disorder. Engaging in a sexual behavior as a response to negative emotional states can be rational, deliberate, and *healthy* (Coleman, 2002). There is nothing inherently impulsive or unhealthy about acting to alleviate one’s dysphoria. Kafka and Krueger (2011) do not offer any suggestions of “healthy” behaviors to decrease stress or improve mood, possibly because any behavior can be dysfunctional.

There are individuals who do pursue their sexual desires “impulsively,” despite recognizing that negative consequences are likely. Missing work deadlines, not attending to childcare responsibilities, or choosing to engage in sex acts above their risk tolerance are examples. Under Kafka’s criteria, this would have to be a frequent occurrence and not limited to just a few occasions. Kafka offers no data on how frequently these individuals report this type of impulsivity. If impulsivity is an important aspect of HD, Kafka should demonstrate that impulsivity exists and occurs with a frequency that generates unwanted consequences.

A hidden assumption in this conceptualization is that it is important to be able to control or reduce one’s sexual fantasies, urges, and behaviors. Many individuals seek out mental health professionals because the content of their desires disturbs them (e.g., women’s rape fantasies) and they have been unable to control or reduce them. The distress often resolves with reassurance and education, rather than focusing on controlling or eliminating these fantasies. Others have been able to “control” the objectionable fantasies, but now complain of a lack of sexual desire.

Is it Non-Paraphilic?

Kafka (2010) contends that the Paraphilias and HD are similar disorders, Paraphilias focus on “non-normative” sexual interests and HD focuses on “normative” sexual interests (normophilia). The HD subtypes (masturbation, pornography, cybersex, telephone sex, strip clubs, and consensual sexual behavior), which Kafka contends “... were deliberately chosen as non-paraphilic behaviors” (Kafka & Krueger, 2011, p. 231), can be applied to either paraphilic (e.g., fetish) or normophilic (e.g., coitus) interests.

Kafka’s conceptualization implicitly suggests that there are important differences between normophilic and paraphilic interests, but attempts at defining this distinction have been criticized repeatedly (see Moser, 2011b; Moser & Kleinplatz, 2005). A number of studies have demonstrated that paraphilic interests are quite common (see Ahlers et al., 2011; Crepault & Couture, 1980; Reynaud & Byers, 1999; Tomassilli, Golub, Bimbi, & Parsons, 2009) and no studies were found suggesting that the non-criminal paraphilias (fetishism, sexual masochism, sexual sadism, and transvestic fetishism) were associated with a pattern of distress or dysfunction (Shindel & Moser, 2011; also see Moser, 2009).

Kafka’s HD diagnostic criteria do not exclude a Paraphilia diagnosis, allowing both diagnoses to be made. As noted above, impulsivity is not part of the diagnostic criteria of the Paraphilias and the criteria which Kafka purports to imply impulsivity in the HD criteria are not part of the Paraphilias diagnostic criteria. If there is a relationship between the Paraphilias and HD, Kafka has not demonstrated it.

Is it Hypersexual?

Kafka (2010) admits he could not define “excessive” sexual behavior and it is quite possible to satisfy the Hypersexual Disorder criteria with a low level of sexual fantasies, urges, or behavior (Hall, 2011). Kafka (1997, 2010) seems particularly concerned about the individual’s Total Sexual Outlet (TSO, number of orgasms from any source) greater than 7/week, but presents no data on the percent of individuals with that frequency who meet the criteria for a HD diagnosis, the percent of individuals who meet HD diagnosis criteria who also have a TSO that high, or the percent of treatment seeking individuals with a frequency that high. Kafka cites a personal communication from Långström that places individuals in the “high hypersexuality” group with a TSO of 4/week for men and 3/week for women (Kafka, 2010, p. 380), about half of Kafka’s concerning frequency. Janus and Janus (1993) found the frequency of all sexual activity at least a few times per week was 53–63% for men and 32–49% for women, depending on their age bracket, suggesting these frequencies are not unusual.

Winters et al. (2010) studied 14,396 participants including 176 individuals who had sought treatment for sexual compulsivity, addiction, or impulsivity. They found no statistically significant difference in TSO between those who had and had not sought treatment. There was also no difference in the reported average frequency of masturbation or the number of partnered sex acts, between the two groups. There was a significant difference in average hours spent per week viewing pornography for men (3.69 versus 6.83; a difference of about 30 minutes a day) for men, but not for women.

There are no data to suggest that most people who meet Kafka's diagnostic criteria for HD have a high TSO. Although some individuals who are distressed about their sexual behavior may have a high TSO, there are no data to suggest that most people with a high TSO either perceive it to be a problem or have a problem controlling their sexual urges or behavior. There is no indication that for most individuals with a high TSO, the time consumed by their sexual fantasies and urges, and by planning for and engaging in sexual behavior is "excessive" or interferes with accomplishing their goals or meeting other obligations. Again, if Kafka means something else by "hypersexual," he needs to define his terms clearly and carefully.

Is it a Disorder or a Symptom of another Disorder?

If the nosology of mental disorders is to be useful, a symptom of another disorder should not be identified as its own disorder. If Hypersexual Disorder is a distinct mental disorder and not a symptom of other disorders, we should be able to identify individuals seeking help for hypersexual behavior who have no other psychiatric diagnoses. Kafka and Hennen (2002) found that 100% of their "Paraphilia-Related Disorder" sample had a lifetime incidence of at least one diagnosable non-sexual DSM axis I diagnosis, with a mean of 2.5 ± 1.0 Axis I diagnoses. Raymond, Coleman, and Miner (2003) similarly found 100% of their Compulsive Sexual Behavior sample had a lifetime incidence of at least one diagnosable non-sexual DSM axis I diagnosis (88% were diagnosable at the time of the interview), with a mean of five Axis I diagnoses. Kafka and Prentky (1994) found 86% of their "Paraphilia-Related Disorder" sample had a lifetime incidence of at least one Axis I diagnosis, with a mean of 2.8 ± 2.1 Axis I diagnoses. Pharmacological treatment (which would treat these other disorders) also decreases the "symptoms" of Paraphilia-Related Disorder an earlier term for HD (see Kafka 2000; Kafka & Hennen, 2000) suggesting that hypersexuality may be a symptom or result of the other disorder.

The characteristics of a sample with a disorder do not define the disorder. Twice as many women as men are diagnosed with Major Depression (APA, 2000), but we do not pathologize being a "woman." Even if 100% of blue-eyed blondes are diagnosed with Dysthymic Disorder, the correct diagnosis is Dysthymic Disorder, not being a blue-eyed blonde. Treatment

should be focused on the dysthymia, not changing the patient's eye color. The conceptualization of Hypersexual Disorder as a separate disorder and not a symptom of another disorder is not supported.

What is the Nature of the Problems Individuals with Hypersexual Disorder Have?

Kafka suggests that it is the “hypersexuality” which leads to “a maladaptive behavioral response with adverse consequences” (2010, p. 385). He suggests individuals with HD are prone to engaging in unsafe sex, acquiring sexually transmitted infections (STI), unintended pregnancy, sexual risk-taking behaviors, and “promiscuity” (which usually implies having more sex partners than the individual making the determination). Considering that almost all of the subtype modifiers of Hypersexual Disorder (i.e., masturbation, pornography, cybersex, telephone sex, and strip clubs) can be seen as *healthy* alternatives, those behaviors would limit these adverse consequences. Only the “Sexual Behavior with Consenting Adults” subtype possibly could increase the individual's risk of encountering these problems. Kafka's formulation paradoxically allows us to conclude that HD actually may prevent the consequences he associates with the disorder.

Some individuals seeking help for their self-perceived out of control sexual behavior do report relationship problems, dysphoria, stress, and impairment in non-sexual functioning associated with the intensity of their sexual interests, but Kafka does not consider the possibility that these symptoms could be a response to the problems emanating from their (or their partners' or family members') discomfort with the content or strength of the individual's sexual fantasies, urges, or behaviors. Whatever problems these individuals may experience, Kafka has not demonstrated that they relate to their “hypersexuality,” rather than the discomfort emanating from their sexual interests or desires. A conflict between the individual and society (related to either's discomfort with sex) is explicitly excluded from the definition of a mental disorder (APA, 2000).

Clinical Judgment

Kafka and Krueger (2011) suggested that “clinically informed judgment” would mitigate any of my concerns about the misdiagnosis of HD. Clinically informed judgment means just that, the expert needs the clinical experience to make that judgment. A goal of the DSM is to allow the non-expert clinician to apply the diagnostic criteria and make a valid and reliable diagnosis. Without appropriate clinical experience, personal bias rather clinical objectivity would predominate. Even with appropriate clinical experience, the effects

of subjective personal bias are difficult to separate from objective clinical judgments. Here is an example:

Mr. A is a 40 year old successful attorney, who has been married for 15 years. He lives with his wife and two children (ages 13 and 10) in suburbs. Since adolescence, he reports sexual fantasies which are intrusive, disturbing, and he is remorseful when he acts upon them. They repetitively interfere with other goals and activities upon which he wants to focus. He reports the frequency of the fantasies, urges, and behaviors increase when he is depressed or anxious. He reports more depression and anger over the last several years as he has tried repeatedly and unsuccessfully to stop or reduce the fantasies, urges, and behaviors. Stressful life events increase the frequency of the urges and behavior, which leads to remorse and more depression; he reports feeling stuck in a tailspin. He recognizes that engaging in the behaviors is harmful in a variety of ways, but this recognition has not changed his behavior. He admits to intrusive fantasies several times a day, including during marital coitus. During “binges” he has engaged in the behavior several times a day, usually with strangers. His wife suspects, but does not know. He keeps pornography at his office locked in a desk drawer. He has contracted various sexually transmitted diseases over the years, but has been able to avoid infecting his wife. He is seeking help to stop.

Most professionals who treat patients with purported “hypersexuality” will recognize this man as a typical patient, perhaps with less denial than most, who meets all of Kafka’s HD diagnostic criteria. Nevertheless, I admit to a bit of subterfuge here. Mr. A was actually seen in 1969 and it was the patient’s homosexuality that was so distressing to him. At the time, “Compulsive Homosexuality” was a term bandied about to describe these individuals and Homosexuality was listed in the then current DSM (APA, 1968). This “problem” was so pervasive that individuals like Mr. A were relatively common fixtures in psychotherapists’ offices. The diagnosis and the patients it afflicted seemed to disappear after 1973, when the APA “depathologized” Homosexuality. In this case, after psychotherapy helped Mr. A to accept his homosexuality, he developed a satisfying relationship with another man. The symptoms and triggers he associated with his sexual urges and behaviors disappeared. Nevertheless, societal bias against homosexuals at the time affected the viability of his law practice, his wife divorced him, and his children rejected any further contact with him. These new stressors did not lead to reemergence of his previously out of control sexuality.

The prevailing “clinically informed judgment” of the therapists and psychiatrists in the 1969 was that Mr. A suffered from a mental disorder (i.e., Homosexuality) and required years of treatment for this disorder. Of course, we now know that treatment was ineffective and we have stopped classifying homosexuality as a mental disorder.

Are the Hypersexual Diagnostic Criteria Useful and Reliable?

Reid et al. (2012) present intriguing evidence that applying the HD diagnostic criteria reliably diagnoses treatment-seeking individuals who are distressed about their sexual behavior. It should be noted that the subjects were drawn from clinics primarily providing treatment to “hypersexual patients” which may explain why the criteria accurately identified patients who themselves “self-identified” with the criteria. If you go to a clinic known to treat people with depression you will find depressed people, no matter which criteria you use.

I also would caution that even if the criteria can be reliably applied, they may not be valid. The identification of reliable criteria does not imply those are the appropriate clinical focus of treatment. Although the DSM is concerned only with diagnosis, not treatment, an inaccurate diagnosis may lead to ineffective or even harmful treatment. If the diagnostic criteria are not properly formulated, treatment may be focused on the effects or correlates of the disorder rather than the underlying disorder.

THE DANGERS OF INCLUDING HYPERSEXUAL DISORDER IN A DIAGNOSTIC MANUAL

Aside from the conceptualization problems, many significant unintended consequences may result from the inclusion of HD in any future revisions to the DSM-5. For example, one potential problem could be the use of HD as an additional diagnostic label in designating individuals as Sexually Violent Predators (SVP; see First & Halon, 2008). The use of these laws is quite controversial and being designated as an SVP is almost always a lifetime “civil” commitment to a psychiatric hospital. However, given that the DSM-5 field trial (Reid et al., 2012) did not apply the HD criteria in sex offending populations, we cannot be certain whether the HD criteria has adequate discriminant validity to avoid classifying false positives in such cases. Moreover, if legislatures wish to increase the sentences of sex offenders, they should act explicitly to do so. Psychiatry should not be a partner in the process and should act proactively to prevent the misuse of its diagnoses. The APA at least at one time agreed that it had “... a strong interest in ensuring that medical diagnoses not be improperly invoked to support involuntary confinement... [and SVP’s] are not mentally ill under normal standards justifying civil commitment” (APA, 1996, p.1). HD as presently conceptualized, risks extending the SVP laws to another group of prisoners, flaunting APA policy.

As Kafka (2010) correctly noted, throughout history there has been concern about excessive sexual behaviors. That concern led to draconian measures to prevent children and the institutionalized from engaging in masturbation (and other sex acts). Many individuals became concerned that

non-marital sex and masturbation were signs of mental illness or would cause other mental and physical illnesses. It is hard to imagine how concerns about “hypersexuality” *would not* suppress healthy sexual development, discourage the healthy use of sex stimulation, produce a new class of the worried well, and create yet another medically sanctioned sexual performance standard for the public. Subsequently, it is likely that the potential risk for abusing an HD diagnosis to the detriment of vulnerable populations far outweighs any potential benefits.

SUMMARY

Kafka has fallen short of clearly demonstrating that the HD conceptualization describes the intended population. The data demonstrating that it is hypersexual, impulsive, or a distinct mental disorder are lacking. The diagnostic criteria are open to interpretation and misinterpretation (see Moser, 2011a). The distinction between the paraphilias and normophilia appears to be artificial and requires further clarification.

The first step in understanding a new disorder is extensive and objective study of those individuals, which appears to be lacking. The current state of our knowledge about individuals who are seeking help for purported “hypersexual behavior” appears to be superficial and characterized by subjective interpretations and preconceptions of the nature of this disorder.

We are left with the initial problem that some individuals seek help because they perceive their sexuality as out of control. It is not clear if this perception is accurate, the result of another mental disorder, a new mental disorder (HD), or a conflict between the individual and society (or the individual’s religious beliefs, self-imposed morality, personal expectations, or a misunderstanding of what constitutes normal sexuality). The argument that these individuals are presenting with a new mental disorder is woefully lacking.

There is reasonable evidence (see Kafka 2000; Kafka & Hennen, 2000) that the treatment of the coexistent psychiatric disorders will ameliorate the sexual symptoms and will be more effective than branding an individual as hypersexual (a disorder that cannot be resolved, only put into remission). The proposal to recognize HD as its own disorder cannot be debated seriously until a consistent combination of diagnostic criteria and conceptualization allow for empirical research to test the existence and characteristics of HD. Objective (rather than subjective self-report) measures of brain pathology, genetic variations, and other biophysiological markers to support HD as a distinct and separate disorder are needed. Sadly, the history of psychiatry is littered with moralistic pronouncements masquerading as scientifically validated entities. The present proposal is another example of politics and moralism rather than science, *caveat emptor*.

NOTE

1. See www.dsm5.org website for updated diagnostic criteria for HD.

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