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LETTER TO THE EDITOR

Hypersexual Disorder: Just More Muddled Thinking

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Kafka (2010) has proposed a new diagnosis, Hypersexual Disorder, for inclusion in the Sexual Disorders section of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), to be published by the American Psychiatric Association (APA). Kafka indicates that "Hypersexual Disorder is conceptualized as primarily a nonparaphilic sexual desire disorder with an impulsivity component" (p. 377). As will be seen, Kafka's proposed diagnostic criteria do not indicate that the sexual interest must be either nonparaphilic or have an impulsivity component.

The problems with Kafka's (2010) proposal are much more pervasive. His "Historical Overview of 'Excessive' Sexual Behaviors" is erroneous (p. 378). He is correct that, throughout history, there has been interest in the "appropriate" frequency of some sexual behaviors, but the frequent behaviors clinically documented by early sexologists (masturbation, non-marital coitus, sodomy) were *not* normophilic for the historical period in which they occurred. The frequency of marital coitus, the only clearly normophilic behavior, was not considered clinically worrisome by most early sexologists.

In contrast to Kafka's (2010) assertion that Hypersexuality has been documented in recent editions of the DSM, that documentation related to the individual's impersonal use of others who exist "only as things to be used" (APA, 1980, p. 283, 1987, p. 296, 1994, p. 538, 2000, p. 582). With the exception of DSM-III-R (APA, 1987), the frequency or normophilic focus of the sexual activity was not mentioned. In DSM-III-R (APA, 1987), the term "sexual addiction" was added, without any definition, and then removed "because of a lack of empirical research and consensus validating the sexual behavior as a bona fide behavioral addiction" (Kafka, 2010, p. 378). That criticism is still valid today. Kafka does not refute this statement by citing new empirical research or consensus validating the sexual behavior as a behavioral addiction. Even if it were validated as a behavioral addiction, it is miscategorized as a sexual disorder. The DSM-5 Substance-Related Disorders category is being expanded to include behavioral addictions, but that workgroup is not considering hypersexuality (sexual addiction) because of insufficient research data (APA, 2010a).

Kafka (2010) reviewed the epidemiological literature, but could *not* find "a distinct bimodal distribution or taxon that effectively defines 'excessive' sexual behavior or hypersexuality" (p. 380). There is no doubt that individuals with all levels of sexual interest exist and individuals can attribute their distress or impairment to their level of sexual interest. Nevertheless, just because the individual (or the psychiatrist) believes the level of sexual interest is problematic does not make it so.

It seems obvious that people who have more sex are more likely to experience more negative (and positive) consequences from their sexual behavior than those who have less sex. Individuals with normative (or low) levels of sexual interest may experience other consequences, both positive and negative. Kafka (2010) presents no data suggesting the purported consequences of Hypersexual Disorder—"sexually transmitted diseases, unwanted pregnancies, severe pair-bond impairments, excessive financial expenses, work or educational role impairment and other associated morbidities" (p. 389)—were related to increased sexual frequency rather than other psychiatric co-morbidities. Kafka and Hennen (2002) found many other diagnoses present in "hypersexual" individuals and *all* of the individuals in the nonparaphilic hypersexual subsample had at least one other Axis I diagnosis. This

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suggests that hypersexuality may be a symptom of other disorders, rather than its own disorder.

Naming the disorder after the behavior introduces diagnostic errors. Individuals who obsessively or compulsively wash their hands may have an obsessive–compulsive disorder (OCD), but they do not have a hand-washing disorder. Similarly, individuals who experience distress or impairment related to their sexual activities may have a psychiatric disorder, but not necessarily a sexual disorder. There is some evidence that people with certain types of psychiatric disorders can have higher sexual frequencies, but essentially no evidence that most individuals with higher sexual frequencies experience distress or impairment related to their sexual frequency.

Kafka's (2010; see also APA, 2010b)[1] proposed diagnostic criteria are presented below. An individual must meet three of five A criteria, as well as the B criterion. The C criterion is an exclusion criterion, indicating the diagnosis should not be made if the disorder is only apparent when the individual is under the influence of a psychoactive substance (but, interestingly, does not exclude medical conditions or cases where another psychiatric disorder better accounts for the "hypersexuality").

The A Criteria

> A1. Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other important (non-sexual) goals, activities and obligations.
> A2. Repetitively engaging in sexual fantasies, urges or behaviors in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
> A3. Repetitively engaging in sexual fantasies, urges or behaviors in response to stressful life events.
> A4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviors.
> A5. Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others. (Kafka, 2010, p. 379).

Criterion A1 assumes that non-sexual goals, activities, and obligations are more important than sexual ones. Kafka seems to discount the possibility that sex itself can be an important and life enhancing activity, which appropriately can take precedence over other activities.

Criteria A2 and A3 both suggest that using sex as mood modulator is a sign of a mental disorder. Kafka does not propose a healthier response to dysphoric moods or stressful life events. Relief of stress or negative mood symptoms by sexual activity appears preferable to medicating with psychoactive substances or comfort food. Using sex to handle stress and mood disturbances is not much different from using exercise, prayer, or meditation for the same purpose.

Criterion A4 seems too broad; many individuals are unsuccessful at controlling or reducing nonsexual urges and behaviors (e.g., eating "unhealthy" food, eschewing exercise, etc.). Would this failure to control nonsexual urges lead to the creation of a new set of non-sexual diagnoses? Would individuals with the discredited diagnosis of Ego-dystonic Homosexuality (APA, 1987) now be diagnosed with Hypersexual Disorder, because they were unsuccessful at controlling their homosexual urges? Of course, an inability to control one's behavior can be a sign of mental illness, but, again, it is not clear that it is, in essence, a sexual disorder.

Criterion A5 suggests that repetitively disregarding the potential for harm is an indication of a mental disorder. By that reasoning, scuba diving, mountain climbing, and freeway driving can be indications of a psychiatric disorder.

Kafka (2010) correctly points out that sexual behavior specifically is excluded from the OCD diagnosis (APA, 2000), because the individual derives pleasure from the activity. Actually, many individuals that Kafka is trying to describe do not derive pleasure from their sexual activity or no more pleasure than the individual with OCD receives when reassured that the stove really is off. Of interest, the same medications useful in treating individuals with OCD are also useful in treating people with sexual compulsions (Kafka & Hennen, 2000).

Criterion B relates personal distress or impairment associated with the frequency and intensity of these sexual interests. The question is: Whose distress? Is it the individual's distress? Is it the distress of the spouse, who is dragging the "patient" to a psychiatrist for engaging in too much masturbation, pornography viewing, cybersex, etc? Is it the distress at being blackmailed ("stop or I am divorcing you")? Is it the distress from living without the type or quality of sex actually desired? Is it the distress at not being able to live up to societal expectations?

Despite the implication of the diagnosis that there is a healthy amount of sex (not too much, not too little, but just right), as it is now written, it is quite possible to meet the diagnostic criteria for Hypersexual Disorder with a below average total sexual outlet. The B criterion describes the distress or impairment from Hypoactive Sexual Desire Disorder as well as Hypersexual Disorder.

There are people who have difficulty controlling their sexual fantasies, urges, and behaviors. These individuals may benefit from psychiatric intervention, but the present formulation of Hypersexual Disorder does not describe these individuals. Individuals and treatment centers touting their expertise in the treatment of "sexual addiction" have been sprouting up without standardized diagnostic criteria, studies of effectiveness, and often without acknowledging that the treatment program is

[1] A somewhat modified version of these criteria is presented on the DSM-5 website, but I do not believe the changes substantially alter any of my comments.

experimental. Adopting this proposal would validate these ethically questionable activities.

In summary, the proposed Hypersexual Disorder diagnosis is based upon faulty and inconsistent logic, imprecise criteria, historical inaccuracies, and poorly conceived constructs. Inexplicably, the empirical basis required for adding a new diagnosis to the DSM is lacking. Using Kafka's own analysis and research, the proposed diagnostic criteria for Hypersexual Disorder have not met his own description of the disorder or defined a new disorder. Hypersexual Disorder is another failed attempt at defining this phenomenon and obviously not ready for inclusion in DSM-5. This proposal is another example of the quasi-scientific muddled thinking that has characterized this concept historically.

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