Assessment, diagnosis, and management of hypersexual disorders

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Purpose of review

This review examines recent advances in conceptualizing and treating hypersexual disorders.

Recent findings

Studies on hypersexual disorders, inferred from research on their associated descriptors, suggest that these disorders have a strong relationship to a number of areas of functioning, in particular, self-regulation and sexually offensive behavior.

Summary

The proposed inclusion of hypersexual disorders in the upcoming Diagnostic and Statistical Manual of Mental Disorders-V may address many of the current issues related to the lack of empirical research on hypersexuality. Although there have been some gains made on understanding hypersexuality, there remains a lack of consensus and empirical research on hypersexual disorders. There are also an insufficient number of controlled studies on the efficacy of pharmacological and psychological treatments for hypersexual behavior problems.

Keywords

excessive sexual desire disorder, hypersexual disorders, sexual addiction, sexual compulsivity, sexual impulsivity

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Introduction

Hypersexual behavior is a phenomenon easily recognized by those who work with persons suffering from it; however, there has been much speculation and debate regarding the best descriptor to be used [1,2]. Clearly, there are individuals who struggle with their ability to control their sexual thoughts, fantasies, and behaviors, for example, those who spend excessive time on the internet for sexual purposes, engage in high rates of consenting sex with other adults, or who exhibit high rates of masturbation.

Nowhere is hypersexuality more of a serious social issue than in the case of those whose hypersexual behavior is associated with sexually offensive behavior towards others. Indeed, meta-analytic studies on the dynamic risk factors of sexual offenders show that sexual preoccupation (a term with similarities to the construct of hypersexual disorder) is the single best predictor of sexual reoffending [3]. Therefore, it is important to better understand it so as to help individuals struggling with this problem as well as their families and friends, and also to be able to protect innocent victims of sexual abuse, typically women and children.

Methodological considerations

Assessing the presence and treatments of hypersexual behavior problems presents many challenges. For example, as a result of the groundswell of support for Carnes' [4,5] notion of sexual addiction in the 1980s and its association with the 12-step Alcoholics Anonymous-like approach, and the subsequent rejection of this view in the 1990s, the field has suffered from a lack of empirical research. Although there was much theoretical debate on the topic, this did not prompt, until very recently, much empirical research. Further, this lack of agreement in the existing literature on the features of problematic or disordered hypersexuality has made it impossible to determine whether researchers are reporting on a similar problem or whether there are multiple types of hypersexual disorders.

The purpose of this paper is to critically review recent advances in conceptualizing and treating hypersexual disorder. The literature was reviewed using *PubMed* and *PsycINFO* for the period between January 2008 and May 2010. Keywords used were 'hypersexual', 'sexual addiction', 'sexual compulsivity', and 'sexual

impulsivity'. Articles or book chapters were selected if they contained or reported data from empirical studies. Neither case reports nor theses are reported in this paper. Other clinically and theoretically important information (including that published before 2008) is also included when relevant.

Diagnosis

The lack of available empirical evidence on hypersexual or comparable disorders has resulted in their complete absence from prior versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Although DSM-III-R (1987) made reference to sexual addiction as one example of a 'Sexual Disorder Not Otherwise Specified' (p. 296), it was not included in previous or subsequent versions of the manual.

However, hypersexual disorder is now being considered for inclusion in the May 2013 release of DSM-V as a distinct clinical disorder and a draft disorder. Disorder criteria have been proposed by the DSM-V Working Groups (see [6•,7••] for a description). Included in the preliminary draft for DSM-V is the following definition of hypersexual disorder: Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria: (A1) A great deal of time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior; (A2) Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability); (A3) Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events; (A4) Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior; (A5) Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others. There is clinically significant personal distress or impairment in social, occupational, or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior. These sexual fantasies, urges, and behavior are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication). The various proposed subtypes of the proposed hypersexual disorder are excessive masturbation, pornography use, sexual behavior with consenting adults, cybersex, telephone sex, strip clubs, and others.

This proposed inclusion of hypersexual disorder in DSM-V not only acknowledges the various facets of the differing descriptors that have been used before, including thoughts, urges, and behaviors, but also identifies the problem as a response to stress and negative mood states [7••]. However, this proposal is not without its critics. For example, Winters [8] has argued that including aspects of the addiction model of dysregulated sexuality into the proposed diagnosis demonstrates at least two problems with these criteria: first, expressed sexuality may serve as a means to ameliorate the negative effect associated with some other underlying mental disorder that, when treated, also alleviates the problematic hypersexuality; and second, if repeatedly engaging in sexual behaviors to enhance mood is symptomatic of a distinct sexual disorder, then we must also be willing to accept that repeatedly engaging in nonsexual but rewarding behaviors for a similar effect is symptomatic of other corresponding mental disorders, in particular if accompanied by impairment in day-to-day functioning. There have also been critiques of the use of the term hypersexual disorder, for example, by those who favor the term sexual addiction [9]. However, few would argue against the inclusion of some descriptor for this disorder in diagnostic manuals so that individuals suffering from it can get the treatment they need and desire, clinicians can be paid for treating these patients, and that empirical examinations can be conducted and compared.

Assessment

The majority of patients self-referred to treatment for a hypersexual disorder are males. To date, there have still not been any large-scale epidemiological studies on hypersexual disorder [10]. This, of course, is partly due to the lack of agreement on what should be measured, and what would be the best method to measure hypersexual behavior, such as, observer diagnosis versus self-report. For example, there has been shown a tendency for lower socioeconomic individuals to over-report sexual addiction whereas sexual offenders tended to under-report [11]. Given the previous lack of clear criteria of hypersexual disorder, there are a number of problems with interpreting research based on observer diagnoses, not the least of which is the low inter-rater agreement on some of the sexual disorders with clear criteria already in the DSM (e.g., [12]). Using the various proxy measures as estimates remains the only method of inferring the potential rates of hypersexual disorder in the general and special populations. However, many of these proxy measures do not give an indication of a cutoff score for ascribing the presence of or indications for a disorder, and much of the research on these measures is on a self-referred clinical population, leaving it impossible to determine actual prevalence rates. There are two exceptions to this general rule, the Sexual Addiction Screening Test (SAST) [5] and the Hypersexual Behavior Inventory (HBI) [13].

The creator of the SAST recommends a cutoff score of 13, out of a possible maximum of 25, for indications for the presence of sexual addiction in respondents.

A number of authors have stated that the rates of sexual addiction in the general population are between 3 and 6% [5,14]; however, the methods and criteria used for these estimates are unclear. In a recent study on indicators for the presence of sexual addiction in incarcerated sexual offenders and a low socioeconomic community comparison group, Marshall *et al.* [11] report rates of more than 40% for the sexual offenders and more than 17% for the community comparison group with values above the cutoff score in the SAST. Although the rates of those individuals with values above the cutoff score in the sexual offender group appear high, this is perhaps not surprising, as it is similar to the rates of sexual preoccupation in sexual offenders reported by Hanson and Morton-Bourgon [3]. The rate in the comparison group (17%), however, is significantly higher than the previously mentioned estimates of the prevalence in the general community. Marshall *et al.* hypothesize that sexual behavior could be less expensive and, therefore, more easily available to low socioeconomic individuals than other forms of dysfunctional coping strategies such as the excessive use of alcohol, drugs, or gambling. However, it could also be that the cutoff score of the SAST is too low and leads to an overestimation of the problem. In addition, the SAST is constructed for screening, not for a formal diagnosis of sexual addiction or hypersexual disorder. Further research is needed to better understand these findings.

Although it is yet to be described in detail in a peer-reviewed publication, the HBI [13] is a 19-item measure of hypersexual behavior that reflects many of the components of the proposed DSM-V criteria and provides a cutoff score for diagnostic purposes. The HBI has three subscales: control over sexual thoughts, urges, and behavior; consequences associated with hypersexual behavior; and the extent to which an individual uses sex to cope with uncomfortable or unpleasant affective experiences. The HBI also provides a cutoff score (53 out of a possible 95) for a diagnosis of hypersexual behavior. Unfortunately, the majority of the research on this measure uses clinical populations, leaving the prevalence of hypersexual disorder still unknown.

Correlates

As noted before, one of the most commonly used self-report measures of problematic excessive sexual behavior, which is at least somewhat analogous to hypersexual disorder, is the SAST [5]. This measure has recently received empirical support in terms of its internal consistency [15], construct validity [16], and factor structure [17]. Recent studies have shown sexual addiction as measured by the SAST to be related to increased risk for boundary violation in physicians [16,18], higher attachment anxiety and avoidance [19], and personality disorders [17].

With regard to sexual offenders, Marshall and O'Brien [20] have recently argued that there are many overlapping features of Carnes' notion of sexual addiction and empirical research on issues associated with sexual offending. In reports using the SAST with sexual offenders, sexual addiction was found to be related to using sex as a means to cope, inappropriate sexual urges, and fantasies, but unrelated to type of sexual offender (child molesters versus rapists), frequency, age of onset, diversity of sexual behaviors, or other measures of addictive behaviors, such as the use of alcohol and drugs [20,11]. This last finding of a lack of relationship to other addictive behaviors is also reported for nonoffenders in a study using the HBI [21]. The SAST has also been demonstrated to be related to the number of victims of sexual offenders, with those sexual offenders with three or more victims demonstrating greater problems with sexual addiction as measured by the SAST [22].

The HBI has been shown to be correlated to problems with executive functioning, most notably in emotional self-regulation, problem solving, planning, and self-management [23]. In a study examining the effects of hypersexual disorder on coping with shame about hypersexual behavior, hypersexuals tended to use withdrawal and self-attack as methods of dealing with their shameful feelings [24]. Using other proxy measures of hypersexual disorder, such as the Compulsive Sexual Behavior Inventory and the Sexual Compulsivity Scale, research on men has demonstrated a relationship between hypersexual behavior and engaging in sexual marathons [25], propensity to engage in high-risk sex [26,27], problems with emotional self-regulation [28], and lower levels of relationship intimacy and sexual contentment [29], whereas in women research has demonstrated a relationship between hypersexual behavior and sexual coercion [30] and sexual risk taking [29]. There have also been recent investigations on the relationship between hypersexual disorders and medical issues, such as epilepsy (e.g., [31]); however, these studies tend to be single-case examinations, but do suggest further investigation into the relationship between hypersexuality and comorbid medical disorders.

Management

As mentioned in the introduction to this paper, there is a dearth of rigorous evaluations of treatment for hypersexual disorders. As this paper is meant to reflect only those papers appearing in the past 2 calendar years and due to space limitations, the interested reader is referred to an excellent review of pre-2008 interventions by Kaplan and Krueger [10].

No empirical evaluations of treatment approaches in the past 2 years could be found using the search engines

described above. Of interest, however, is the empirically based, but untested, attention to the impact of childhood trauma on the therapeutic relationship. Katehakis [32•] reports that early negative childhood-attachment experiences have a neuropsychobiological impact on individuals with sexual addiction, which significantly affects their affective, cognitive, and behavioral development. She suggests that therapists should be aware of how these early experiences can disrupt the therapeutic relationship and suggests strategies for dealing with these types of sexually addicted patients. Briken and Basdekis–Jozsa [33] in their conceptual paper describe a three-step psychotherapeutic approach depending on the severity of the disorder. They also recommend pharmacological treatment, especially with serotonin-enhancing medication.

Conclusion

There still remains a lack of consensus and empirical research on hypersexual disorders. Thus, the efforts currently made by the DSM-V study group [6•,7••] to develop diagnostic criteria and to empirically study the reliability and validity of the construct in the planned field trials could lead to an important improvement. Clear diagnostic criteria are a necessary precondition to test the efficacy of pharmacological and psychological treatments in controlled studies in the future.

References and recommended reading

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Additional references related to this topic can also be found in the Current World Literature section in this issue (p. 613).

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