

Too much sex, a mental disorder? Examining both sides of the debate on hypersexual disorder

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Abstract

In recent decades, the concept of pathological, excessive sexual behaviour has been a source of ongoing controversy. This controversy is centered on defining the characteristics of excessive sexual behaviours and the extent to which these behaviours should be considered pathological. This debate was intensified after Kafta (2010)'s proposed the inclusion of hypersexual disorder in the DSM-5. According to Kafta's proposal, for a person to be diagnosed with the disorder, he or she must have recurrent and intense sexual fantasies, urges, and behaviours which are not due to direct physiological effect of a drug-related substance and which cause significant personal distress or impairment (American Psychiatric Association, 2010). This literature review is intended to examine whether or not hypersexual disorder should be included in the DSM-5 based on current research literature in the field. Arguments for and against its inclusion in the DSM are reviewed. In sum, there is still a lack of consensus on the specific criteria for diagnosis, the theoretical approach to the disorder, and on how to measure hypersexual sexual behaviour; thus it is still too premature to include hypersexual disorder in the DSM.

Keywords: *hypersexuality, sexual addiction, sexual compulsive disorder, sexual disorder, DSM-5*

Excessive sexual behaviours have long been discussed and described in Western medicine. As early as the 1940s, terms such as nymphomania and Don Juan Syndrome were used to describe excessive sexual desire or behaviours (Rinehart & McCabe, 1997). In 1983, Carnes proposed the concept of sexual addiction as a diagnosable and treatable mental disorder in his controversial book, *Out of the Shadows: Understanding Sexual Addiction*. Carnes

(1983) suggested that sexual addiction stems from an inability to effectively control one's sexual desires or behaviour. Over the recent decades, the concept of pathological, excessive sexual behaviour has been an ongoing source of controversy. This controversy is centered on defining the characteristics of excessive sexual behaviours and the extent to which these behaviours should be considered pathological. New labels for excessive sexual

behaviours, such as “compulsive sexual behaviour” (Coleman, 1990), “hypersexual disorder” (Kafta, 2010) and “paraphilia-related disorders” (Kafka, 1997), have since been introduced.

This debate was intensified after Kafta (2010) proposed the inclusion of hypersexual disorder in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). In his proposal, hypersexual disorder is conceptualized as a sexual desire disorder with an impulsivity component. For a person to be diagnosed with this disorder, he or she must have recurrent and intense sexual fantasies, urges, and behaviours which are not due to the direct physiological effects of a drug-related substance and which cause significant personal distress or impairment in social, occupational or other important areas of functioning (American Psychiatric Association, 2010). Examples of the sexual fantasies, urges and behaviours specified in the proposal include masturbation, cybersex, telephone sex, viewing pornography, and visiting strip clubs, and they are said to have the potential to become excessive (American Psychiatric Association, 2010). According to *U.S. News and World Report* (2010), if the proposal is passed by the DSM-5 Working Groups, hypersexual disorder may appear in the DSM by 2012. In this review, I will focus on the controversy surrounding hypersexual disorder by examining arguments for and against the inclusion of hypersexual disorder in the DSM-5.

There are three main arguments for the inclusion of hypersexual disorder in DSM. First, as stated by the DSM-5 Work Group, many mental health professionals have expressed the clinical need for such a diagnosis (American Psychiatric Association, 2010). There seems to be a distinct group of

men and women who have been seeking clinical help for their “out of control” sexual desire and behaviour. The adverse consequences associated with this condition include significant marital dysfunction (Muench et al., 2007), a higher risk of sexually transmitted infections (Langstrom & Hanson, 2006; McBride, Reece & Sanders, 2008), unwanted pregnancies (Henshaw, 1998; McBride et al., 2008) and work and/or educational role impairment (Cooper, Golden, & Kent-Ferraro, 2002). Many health clinics offer treatments such as 12-step group support, individual psychotherapy and pharmacotherapy for these individuals (American Psychiatric Association, 2010). Currently, these people are diagnosed using the rather unsatisfying label, “Sexual Disorder Not Otherwise Specified” under DSM-IV-TR. An increase in clarity in the diagnostic criteria for such conditions could provide a starting point for testing and refining the proposed diagnostic criteria. It could also facilitate and stimulate more research in this area and consequently enhance the quality of treatments.

Secondly, this group of people that are seeking clinical help for their out-of-control sexual behaviours can be distinguished from non-clinical samples by their increased expressions of normative sexual desire (Kafta, 2010). Over the past decade, Kafka has conducted numerous studies examining clinical samples of men with paraphilia-related disorder, which is another term for hypersexual disorder used in the research literature (e.g., Kafta, 1997; Kafta & Hennen, 2003). He consistently found that this group of men was characterized by having seven or more orgasms per week (Kafta, 1997; Kafta & Hennen, 2003). This frequency of orgasms is two or three times greater than those observed in studies investigating average male undergraduate participants’ sexual

behaviour and experiences (Pinkerton, Bogart, Cecil, & Abramson, 2002). In his research paper, Kafta (1997) expressed a genuine concern for the men in his clinical sample, citing that the majority were married men with a mean age of thirty-six, and masturbated more times per week on average than single men in their early twenties.

Several empirical studies based on non-clinical samples also found that a small proportion of men's and women's sexual experiences were characterized by excessive sexual desire and behaviour. For example, Kinsey, Pomeroy and Martin's (1948) famous study employing a large non-clinical sample of 5,300 American participants reported that only 8% of American men had weekly orgasm frequencies totalling seven or more. A subsequent investigation of high school and college men also found that only about 3% to 5% of American men masturbated on a daily basis, suggesting that they were experiencing at least seven orgasms per week (Atwood & Gagnon, 1987). In contrast to these relatively high frequencies of masturbation and orgasm, a 2010 research study indicated that the average male undergraduate student only masturbates three times per week (Pinkerton et al., 2002). Based on this empirical evidence, Kafta (2010) proposed that hypersexuality could be operationalized as a weekly average of seven or more orgasms over a period of at least six months.

Many researchers argue that hypersexual disorder stems from genuine psychological and behavioural dysfunction that can cause functional impairment and personal distress, and thus should be considered a mental disorder. For example, Stein (2008) stated that hypersexual disorder is caused by a dysfunction of the neural circuits of the reward system in the

brain, particularly the amygdala and the ventral striatum, which is also associated with other addictive pathological disorders such as alcohol addiction and pathological gambling. Stein's hypothesis is derived from the addiction model that has been proposed to explain the etiology of hypersexual disorder (Carnes, 1984). According to the Carnes' (1984) addiction model, people who experience excessive sexual fantasies and behaviours often fail to control or reduce the frequency of their sexual activities and continue to engage in such activities despite a plethora of adverse consequences, such as the potential increased risk of contracting STIs and/or the instigation of marital and relationship dysfunction. This behaviour pattern is similar to that seen in drug addiction. Another analogue to drug or alcohol addiction is that these individuals may also experience withdrawal symptoms such as depression, anxiety and guilt. The popular 12-step recovery program for "sex addicts" is built upon this theoretical approach. Wines' (1997) study including 53 participants who identified themselves as sex addicts offered empirical support for the addiction model. More than 94% of the participants in this investigation reported failed attempts to stop or reduce their sexual desire or behaviours and 98% reported three or more withdrawal symptoms, such as depression, insomnia and fatigue.

Other researchers such as Coleman (1990) suggest that hypersexuality is associated with compulsivity. Unlike the addiction model that focuses on the failure to control one's sexual behaviour, the compulsivity model of hypersexual behaviour emphasizes the intrusive sexual fantasies and irresistible urges associated with hypersexual disorder. According to this model, some individuals have compulsive

urges to engage in repetitive sexual behaviour in order to reduce anxiety and other dysphoric effects such as shame and depression (Coleman, 1990). Based on this model, Kalichman and Rompa (1995) developed the Sexual Compulsivity Scale (SCS). Several studies have demonstrated the reliability and validity of SCS (Dodge et al., 2004; McBride et al., 2008). Higher scores on the SCS are correlated with an increase in frequency of masturbation and an increased number of risky sexual behaviours, such as engaging in sexual behaviour with large number of partners or the constant failure to use condoms when engaging in casual sexual intercourse (Dodge et al., 2004; McBride et al., 2008). This scale's high reliability and validity indicate that sexual compulsivity may indeed be a valid psychological construct.

Based on the addiction and compulsivity models of hypersexuality, hypersexual disorder shares common etiologies with alcohol addiction and obsessive-compulsive disorders, which are highly co-morbid with other mood disorders and developmental disorders (disorders that hinder children's motor or cognitive development). Therefore, it is reasonable to suspect a high co-morbidity rate between hypersexual disorder and other psychiatric disorders, such as depression, general anxiety disorder and attention deficit hyperactive disorder. Indeed, many research studies have found that excessive or compulsive sexual behaviour is often co-morbid with many other disorders in Axis I of the DSM such as those mentioned above. For example, Black et al. (1997) interviewed 36 participants who exhibited compulsive sexual behaviour. The researchers reported that 37% of the sample had a history of major depression and 42% had a history of phobia disorder. In a recent study, Raymond,

Coleman and Miner (2003) reported similar findings. They interviewed 25 participants who reported sexually compulsive behaviour and found that 88% of the participants also met diagnostic criteria for an Axis I disorder, the most common disorders being anxiety and mood disorders.

However, Kafta (2010) argues that because not all people exhibiting hypersexual behaviour meet the criteria for a co-existing mood or anxiety disorder, hypersexual disorder may reflect a distinct underlying psychopathology. Based on the high co-morbidity rate and the current theoretical approaches to hypersexuality, Kafta (2010) concludes in his proposal that hypersexual disorder is a genuine psychopathology, which is associated with a loss of control over sexual behaviour and the maladaptive use of sexual behaviour in response to negative emotions or other life stressors.

In contrast, opponents have put forth four major arguments against the inclusion of the hypersexual disorder in the DSM. First, many researchers have questioned the validity of the diagnostic criteria proposed by Kafta (2010). Some researchers have raised doubt about the validity of Kafta's operationalization of hypersexual behaviour as a weekly average of seven or more orgasms (Kingston & Firestone, 2008; Winters, 2010). Recent data has failed to support Kafta's proposal that a weekly average of at least seven orgasms will only capture a small proportion of the population that could potentially be diagnosed with hypersexual disorder. For example, Winters, Christoff and Gorzalka (2010) conducted a study using a large community-based convenience sample and found that 44% of men and 22% of women reported a total weekly orgasm count of seven or more. Because of lack of support for the Kafta's

original operationalization of hypersexual behaviour, Kafka has removed this controversial criterion from his most recent proposal for hypersexual disorder (Kafka, 2010). Without empirical support for criteria to identify hypersexual disorder, it becomes a challenge for clinicians to make accurate diagnoses and to include hypersexual behaviour as a disorder in the DSM-5.

Many researchers have also questioned the utility of pathologizing individuals' pursuit of sexual behaviours to enhance mood or as a strategy aimed to reduce stress (Moser, 2010; Winters, 2010). Many people engage in other rewarding activities, such as hobbies and work, to alleviate negative mood or to relieve stress, even if it may impair other aspects of their lives such as their marital relationship. Additionally, Kafka's interpretation of the high co-morbidity rate of hypersexuality with other DSM disorders has also been criticized. Both Moser (2010) and Winters (2010) have questioned the directionality of the correlation between hypersexual behaviours and other mental disorders. They argue that this high co-morbidity simply reflects the fact that hypersexuality may be a symptom of other disorders. Some people may use sexual fantasies and behaviours to alleviate the negative emotions that stem from their underlying mood and anxiety disorders (Winters, 2010). Therefore, if the underlying disorder(s) are treated, the maladaptive sexual fantasies and behaviours should also be ameliorated (Winters, 2010). In short, opponents argue that there is insufficient data in support of the diagnostic criteria proposed by Kafka (2010).

The second major argument against the inclusion of the hypersexual disorder in the DSM points to a myriad of methodological flaws in hypersexuality research. The

majority of research studies in this area are based on self-report measures from small clinical samples without valid comparison groups. For example, most of Kafka's research studies on paraphilia-related disorders were based on clinical samples who sought help for their hypersexuality (e.g. Kafka, 1997; Kafka & Hennen, 2003). These clinical samples may vary systematically from those who did not seek treatment for excessive sexual behaviours. In Winters et al.'s (2010) study comparing a treatment sample with a non-treatment sample, it was found that men who sought treatment for their excessive sexual behaviours were more likely to belong to an organized religion and to feel that that religion was essential to their lives. This difference could impact the results of studies in this area, as previous studies have found that increased religiosity is correlated with negative sexual attitudes (De Visser et al, 2007). Therefore, it may be especially distressing for individuals high in religiosity to have high sexual desire and this may make them more likely to seek treatment.

In addition, the majority of studies in this area rely on retrospective reports of symptoms. For example, Wines' (1997) study (cited in Kafka's proposal) was a retrospective study based on participants who identified themselves as sex addicts and who participated in the Twelve-Step Alcoholics Anonymous-type program. Kaplan and Krueger (2010) have noted the limitations of these retrospective designs, including inaccurate and exaggerated reports of the frequency and severity of symptoms. It is possible that the men seeking treatment are highly motivated to change their sexual behaviours; thus they are more likely to over-estimate the severity of their symptoms before treatment.

The third main argument against the inclusion of hypersexual disorder in the DSM centers on the lack of consensus around the theoretical approach behind the disorder and the lack of solid empirical evidence for each proposed theoretical approach. The addiction model and the sexual compulsivity model mentioned in Kafta's (2010) proposal remain controversial. The aforementioned methodological flaw present in retrospective data has made Wines' (1997) findings very difficult to interpret and thus limits their ability to lend solid support for the addiction model. Upon reviewing the literature on the addiction model, Kafta (2010) also concluded in his proposal that there is a lack of empirical evidence for a specific withdrawal state and tolerance symptoms in hypersexual disorder, which are parallel with those in other addiction disorders. Thus, further studies are needed to support the utility of this model.

Although the sexual compulsivity model has received more support than the addiction model, several studies have failed to support this model. For example, Quadland's (1985) study, comparing results from participants seeking help for their compulsive sexual behaviour to those of matched controls seeking clinical help for non-sexual problems, found no group differences in mood or anxiety disorders. In his comprehensive review of 30 patients who volunteered themselves for clinical interventions for excessive sexual behaviour, Levine (2010) concluded that half of the sample was inadequately described using addiction and compulsivity models. In the majority of cases, participants sought treatment because their spouses criticized them as being "sex addicts", reflecting a sexual desire incompatibility between partners, not a sexual disorder (Levine, 2010).

Another theoretical approach has been introduced to overcome the limitations of previous models, namely, the dual control model (Bancroft & Vukadinovic, 2004). This model suggests that sexual arousal is determined by a balance between the sexual activation system and the sexual inhibition system in the brain (Bancroft & Vukadinovic, 2004). According to this model, people with a particularly high propensity for excitation or low propensity for inhibition are more likely to engage in problematic or excessive sexual behaviour. This new approach has received increasing research interest and has been tested against other models. If this model receives sufficient empirical evidence in the future, it would become necessary to incorporate it into the diagnostic criteria for hypersexual disorder.

In order to fulfill the DSM's criteria for a mental disorder, hypersexual disorder must manifest as a genuine psychological or behaviour dysfunction (American Psychiatric Association, 2009). Therefore, it is important for researchers in this area to arrive at some consensus on the explanation of hypersexual disorder (Winters, 2010). Until such consensus has been reached, it may be premature to include this disorder in the DSM-5.

The fourth argument against the inclusion of the hypersexual disorder in the DSM is focused on criticisms concerning the concept of "hypersexuality" itself. Gagnon and Simon (1973) introduced the term "sexual scripts" to refer to a set of social norms and values that govern the sexual behaviour of a specific cultural group. Different cultures vary widely in their sexual scripts and this may account for the large variations in what cultures regard as normative sexual expression (Levine & Troiden, 1988). For example, some cultures hold "sex-positive" scripts, in which high

level and wide variety of sexual activities are considered be normal; other cultures hold “sex-negative” scripts in which low sexual activities are deemed to be more appropriate. In criticizing the concept of sexual compulsivity, Levine and Troiden (1988) contrast a “sex-positive” Mangaia culture and a “sex-negative” Irish culture:

Among the sex-positive people of Mangaia, casual sex with different partners, and frequent intercourse with multiple orgasms are perceived as sexually normal....[In contrast], the sex-negative Irish.... consider abstinence and monogamy as normative and typically report low levels of sexual desire and low frequency of sexual intercourse (p.351-352).

Moser (2001) suggests that in pathologizing mental disorders, innate therapist and cultural biases should be avoided. However, as shown by the examples above, hypersexuality is by no means free of cultural biases. Many researchers caution that the pathologizing of hypersexuality may cause clinicians with conservative or negative attitudes towards sex to impose a pathological label on normal sexual behaviour (Kaplan & Krueger, 2010; Moser, 2001). Halpern (2011) also addresses the possible legal consequences of misusing the concept of hypersexuality. If hypersexual disorder is included in the DSM without solid empirical evidence supporting the validity of such a disorder, arrestees charged with violations of laws prohibiting child pornography or with other sex offences may be able to claim that they were afflicted with hypersexual disorder, and be absolved of their charges or be allowed more lenient sentencing (Halpern, 2011).

Having considered both sides of the argument, I feel that there is not enough empirical evidence to show that hypersexual disorder represents a genuine psychological or behavioural dysfunction, thus it is still too premature to include it in the DSM. Although DSM-5 Work Group argues that the inclusion of the disorder in the DSM stimulates research, this argument in itself cannot be grounds for its inclusion (American Psychiatric Association, 2010). The lack of a diagnostic label has not hindered research in this area, as evidenced by the large number of research studies done on this topic in recent decades. Proponents also argue that hypersexual disorder is a genuine mental disorder and individuals afflicted with this disorder can be identified by meeting the criterion of having a weekly average of at least seven orgasms (e.g. Kinsey et al., 1948; Kafta, 2010). However, the lack of consensus on the specific criteria of the diagnosis, the theoretical approach of the disorder, and the measurement of hypersexuality demonstrate that there is still insufficient evidence to support hypersexual disorder as a genuine psychological disorder. Furthermore, many of the research studies supporting the models for the disorder have foundational limitations in methodology, such as small sample sizes, the use of clinical samples, and retrospective designs. These methodological limitations severely compromise the analysis and generalizability of research findings.

Considering opponents’ concern about the possible misuse of the concept of hypersexuality, a more solid research foundation needs to be established in order to suggest that hypersexuality is a genuine psychological or behavioural dysfunction. This needs to be established before it can be included in the DSM. Further research

should continue to test long-standing and current theoretical models as they apply to hypersexual disorder, and should use more community-based samples and employ a variety of methodologies. Specifically, more rigorous research is needed to establish the links between human neurobiology and different models of hypersexual disorder in order to rule out models that are less valid. To address opponents' criticism that hypersexuality is a value laden and culturally biased disorder, more cross-cultural research is also needed to examine both normative and excessive sexual behaviours in different cultural contexts. As with many studies examining complex human social behaviours, research on hypersexuality should not be limited to convenience samples of North American undergraduate students and should include adult participants of all ages from a wide variety of cultural and religious backgrounds.

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The author declared they have no conflicts of interests with respect to their authorship or the publication of this article.

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