

*Conceptualizing and Diagnosing
Problematic Hypersexuality: A Critical
Evaluation of Current Practice*

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Introduction

- A controversial and elusive concept
 - A continuum of normative behaviour? (Giles, 2006)
 - Definitional variability (Kingston & Firestone, 2008)
- Prevalence
 - 3% - 6% of general population (Black, 2000; Carnes, 1989; Coleman, 1992; Goodman, 1993)



Defining Hypersexuality

- Pathological relationship with mood altering experience (Carnes, 1989)
- Behavioural indicators
 - Total Sexual Outlet (Kinsey et al., 1948)
 - Population data indicates statistically rare for males (5-11%) to masturbate more than 7 times per week (Janus & Janus, 1993) or > 15 times per month (Langstrom & Hanson, 2006)
 - TSO \geq 7 times per week and > 1 h/day (duration 6 months; Kafka & Hennen, 2003; Kafka, 2007)



Defining Hypersexuality

- Cognitive, emotional, personal distress features
- Adverse consequences
 - Health consequences
 - Financial and legal consequences
 - Interpersonal consequences
 - Emotional consequences

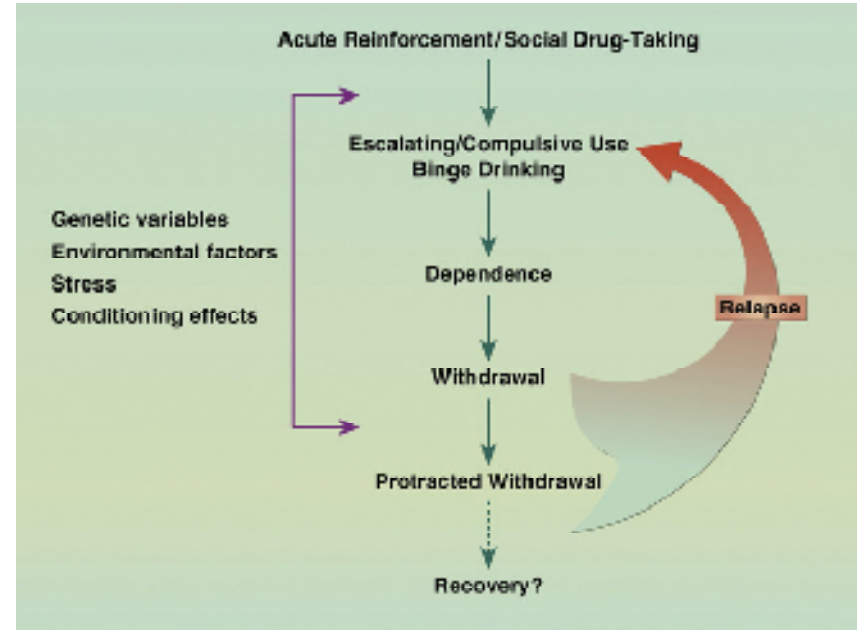


Diagnostic Assessment

- ICD-10 (WHO, 1992)
 - Excessive sexual drive (Satyriasis and Nymphomania)
 - No specified criteria (Briken et al., 2007)
- DSM (APA, 2000)
 - No formal diagnostic category
 - Sexual disorders (NOS)
 - Also classified under other related (or unrelated) diagnoses

Conceptual Perspectives: Sexual Addiction

- Addiction (Koob et. al., 1998)
- Impulsive → compulsive
- Other features
 - Tolerance
 - Withdrawal
 - Inability to stop despite adverse problems
- Behavioural Addictions?



Conceptual Perspectives: Compulsive Sexual Behaviour (CSB)

- Similarities between OCD and PH
 - Intrusive thoughts associated with anxiety/tension
 - Initially resisted → reduce negative emotions → tension/distress
- Empirical support (Black et al., 1997; Coleman, 1990)
- Contradictory clinical features evident
 - Exciting thoughts (impulsivity)
 - Problematic model adaptation
 - Low comorbidity (Jaisoorya et al., 2003)



Conceptual Perspectives: Impulsive Sexual Behaviour

- Failure to resist impulse to commit an act
- Motivational mechanisms are inconsistent
- Some support from comorbidity studies
 - 38% life-time comorbidity (Raymond et al., 2003)
- Positive (impulsive) vs. negative (compulsive) emotions guiding behaviour



Conceptual Review

- Three broad conceptualizations intended to explain etiology and formulate treatment
 - Addiction, OCD, and ICD
- Essential features:
 - a) personal distress/impaired functioning
 - b) disinhibition
 - c) regulation of emotions
- Regulating emotions: Impulsive vs. Compulsive
 - Orthogonal vs. dependent construct



The Sexual Desire Disorders Model

(Kafka, 2007)

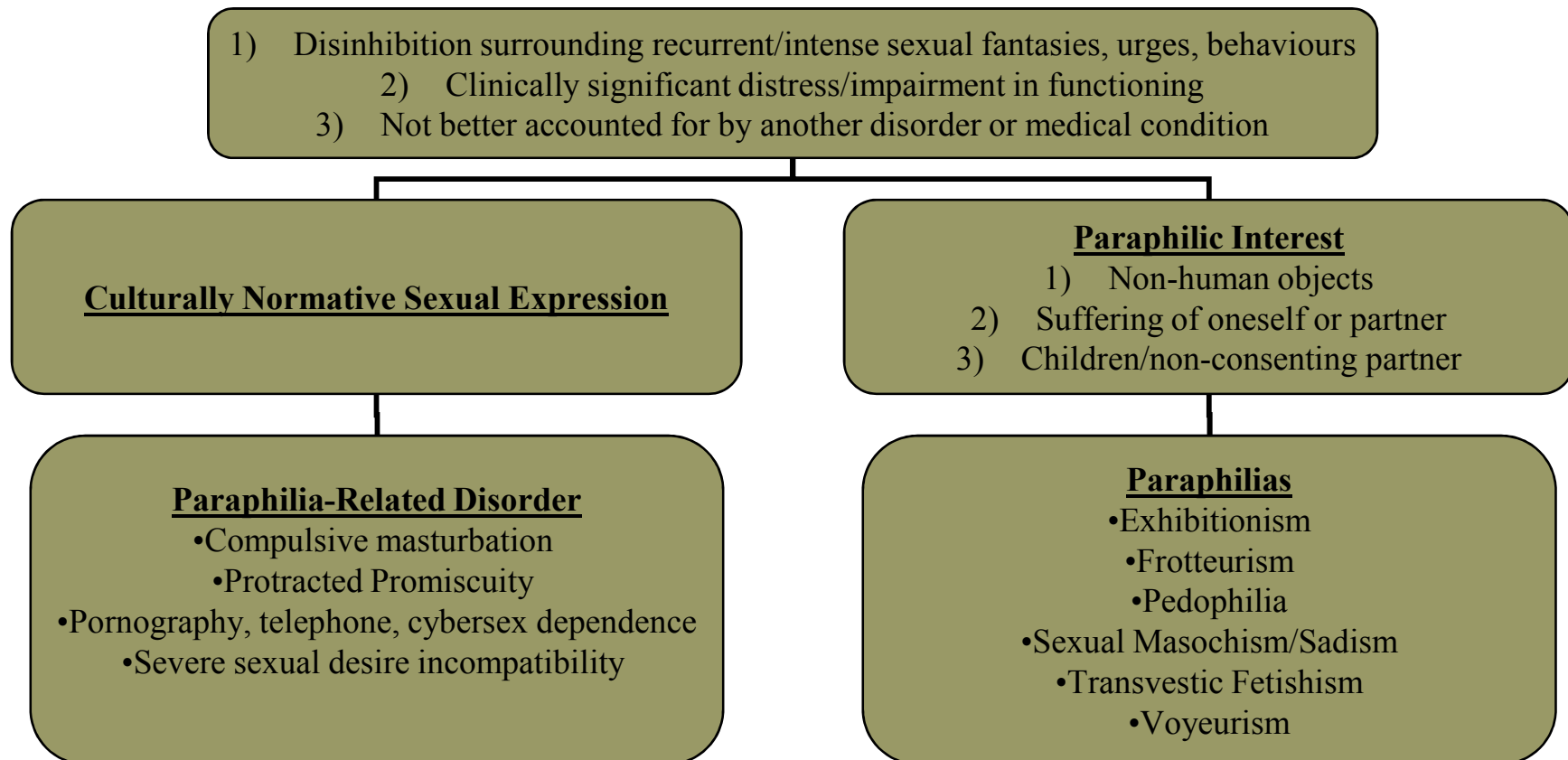
- A. Recurrent, intense, sexually arousing fantasies/sexual urges/or behaviours involving **culturally normative** aspects of sexual expression that increase in frequency or intensity so as to significantly interfere with the capacity for reciprocal, affectionate activity
- B. Clinically significant distress/Impairment
- C. Not better accounted for by another primary Axis I condition, psychoactive substance abuse, or general medical condition



Paraphilia-Related Disorders (Kafka, 2007)

- ❑ Excessive expressions of culturally tolerated sexual behaviours
- ❑ Typically male (5:1 male-female)
- ❑ Adolescent onset
- ❑ Comorbid with other hypersexual behaviors
- ❑ Ego-syntonic or ego-dystonic – intensified during periods of stress

Diagnostic Implications: SDDM (Briken et al., 2007; Kafka, 2007)





Treatment Implications

- Effective treatment follows theoretical models
- SDDM does not presume particular pathways to PH
- Differentiating compulsive and impulsive traits allows for more treatment flexibility
 - Impulsivity = decreased motivation/treatment efficacy
 - May benefit from motivational techniques

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