JOURNAL OF PSYCHOPATHOLOGY
2018;24:187-191

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Hypersexuality: a controversial mismatch of the psychiatric diagnosis

Summary

Hypersexuality is characterized by intrusive fantasies and thoughts regarding sex, excessive sexual behaviours, and the inability to control one's own sexuality, resulting in an impairment of relational and social life. While several clinical histories and empirical research consider hypersexuality as a disorder, the last version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) does not include hypersexuality as a psychopathological category in se. This has generated controversy among clinicians and researchers and a mismatch with the 11th revision of the International Classification of Diseases (ICD-11). However, different theoretical models are related to hypersexuality, i.e. the compulsivity model, the impulsivity model and the addiction model. This paper addresses the psychopathology of hypersexuality, including treatment and related comorbid conditions.

Key words
Hypersexuality • Comorbidity • Treatment • ICD-11 • DSM-5

Introduction

Sexual behaviour represents a fundamental aspect of human life, mainly involving pleasure, reproduction and couple relationships. Sexual physiology consists of several phases according to the gender and problems can occur in some cases. The most common sexual problems are erectile dysfunction and premature ejaculation in males and anorgasmia or sexual pain in females [1]. In some cases, the main cause of a sexual impairment is hypoactive sexual desire disorder, i.e. lack of libido, that causes a decrease of sexual activity. On the contrary, hypersexuality includes excess of sexual activities, the obsession toward sex and its consequences. Hypersexual behaviours include excess of compulsive masturbation, pornography, sexual behaviour with consenting adults, cybersex or telephone sex use and strip clubs attendance [2].

In the last years, the debate was on whether to include hypersexuality within the last version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), with some proposals based on diagnostic criteria, but to date the psychiatric nosography has not considered hypersexuality a mental disorder *per se*. On the contrary, the World Health Organization has recently proposed to include hypersexuality within the last version of the International Classification of Diseases (ICD-11) as a disorder of sexual compulsive behaviour (compulsive sexual behaviour disorder, CSBD) [3]. This generates a mismatch and controversy for the clinical and diagnostic praxis. Is hypersexuality a disorder for psychiatrists and clinical psychologists? In 2010, prominent American psychiatrist M.P. Kafka proposed the criteria to detect hypersexuality [4], but the American Psychiatric Association (APA) still does not include this condition as a category of mental disorder, although the debate is currently open [5]. However, the impossibility to diagnose hypersexuality according to DSM-5 criteria does not mean that this condition does not exist, since several empirical data

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and the clinical practice demonstrate a large pathological spectrum characterizing this particular sexual condition [6]. The aim of the current paper is to highlight the main theoretical models and the state of art of hypersexuality in the field of psychopathology.

Theories of hypersexuality

Theoretical debate concerning the hypersexuality started with Freud's psychoanalytic theories. In particular some authors in this field discussed about the relationship between life instinct and death instinct in sexual addiction [7]. From this perspective, hypersexual/addicted subjects attempt to antagonize depressive states and death anxiety with the life instinct through sexual activities, although in a deregulated way. Hence, hypersexual behaviours can be bona fide considered a defensive behaviour against death anxiety [8].
However, other theoretical models were developed based on different aspects leading to hypersexual disorder: the compulsive sexual behaviour, the sexual impulsivity, and the sexual addiction.

Compulsivity model

Coleman described and defined hypersexuality as a compulsive sexual behaviour through a parallelism with the phenomenology of obsessive-compulsive disorder (OCD), characterized by repetitive and intrusive thoughts and then the repetition of sexual experiences. These experiences are described by an increase of arousal before – and a decrease after – a sexual act [9]. According to this model, thoughts and images constitute the obsession, while the acting constitutes the compulsion. However, this psychopathological mechanism in hypersexuality is ego-syntonic [6].

Impulsivity model

According to this model, the hypersexual behaviour is due to the failure to resist to sexual drive, and to the incapacity to delay the sexual gratification [6]. Based on the impulsivity model, the hypersexuality is thus caused by impulse dyscontrol, although this proposal has been largely criticized. Many hypersexual subjects, in fact, carefully plan their sexual activities and behaviours. Moreover, the reward system related to the pleasure experience would reinforce the hypersexual behaviour [10]. However, according to some studies, sexual impulsivity and sexual compulsivity are factors characterizing hypersexuality together and not separately [10].

Addiction model

The addiction model is considered the most valid to explain the hypersexual disorder. The parallelism between hypersexuality and the common addiction disorders was made in the past [11]. The symptomatology concerns the increase of sexual activity together with the development of the disorder, while abstinence symptoms as depression, anxiety, and blame are associated to the decrease of sexual conducts [11]. Moreover, as in other forms of addiction, hypersexual subjects spend a particular amount of time looking for novel sexual partners and compromise their social and relational life, without taking into account potential negative consequences as the sexually transmitted diseases.

ICD-11 *versus* DSM-5

The categorial approach towards mental disorders regards both the ICD and the DSM classifications, however the ICD proposed to include hypersexuality as a condition in its last version (ICD-11). Hypersexuality has an estimated prevalence of 2-6%, with males being the most affected [12 13]. This high prevalence, in absence of specific diagnostic criteria, drove some clinicians and epidemiologists to categorize and propose hypersexuality as a distinct disorder. In particular, the World Health Organization proposed to describe hypersexuality as a compulsive sexual behaviour disorder (CSBD), describing it in the ICD-11 as follows:

Compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour. Symptoms may include repetitive sexual activities becoming a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities; numerous unsuccessful efforts to significantly reduce repetitive sexual behaviour; and continued repetitive sexual behaviour despite adverse consequences or deriving little or no satisfaction from it. The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behaviour is manifested over an extended period of time (e.g., 6 months or more), and causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviours is not sufficient to meet this requirement [14].

Moreover, an additional controversial aspect is the position of CSBD among the impulse control disorders together with pyromania, kleptomania and intermittent explosive disorder, as also the various substance impulse control disorders [14]. According to the ICD-11 classification, the only conditions to be excluded when diagnosing CSBD are paraphilic disorders. The ICD-11 made also a further specification concerning the terminology: hypersexuality or hypersexual disorder is better defined as compulsive sexual behaviour disorder.

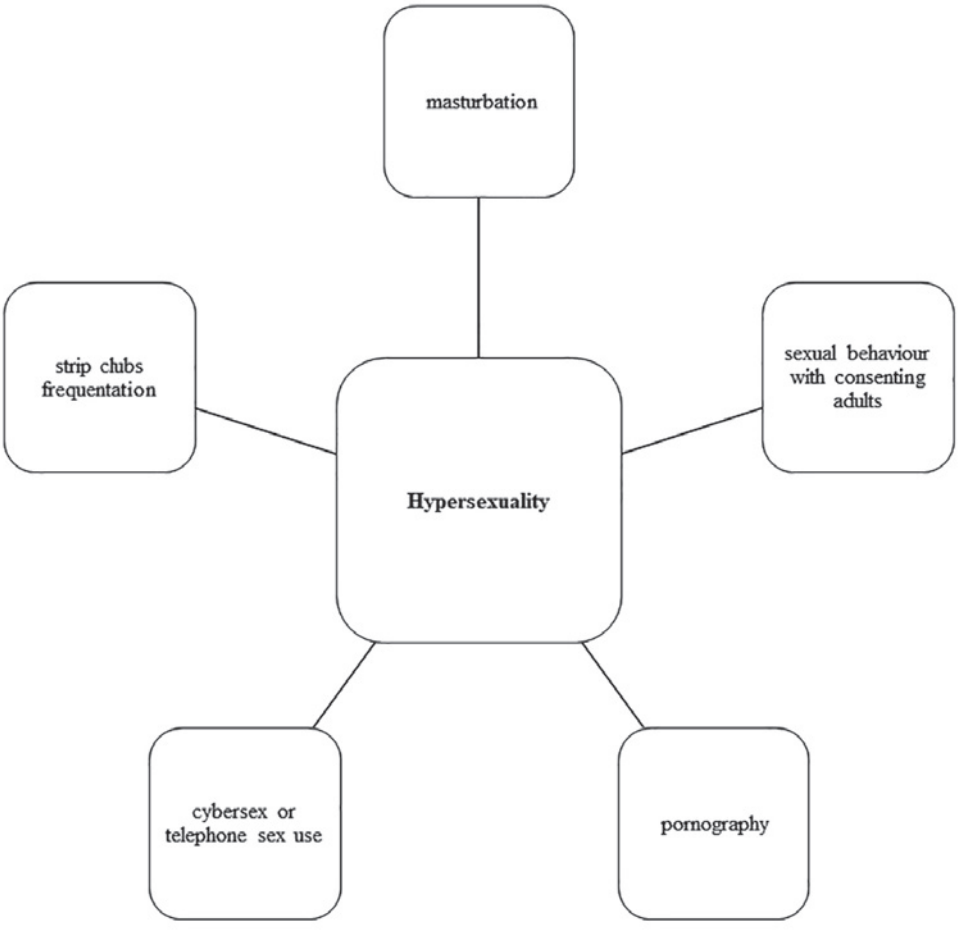
On the other hand, hypersexuality was considered for inclusion as a psychiatric disorder within the section of sexual dysfunctions of the DSM-5. The DSM-5 Working Group on Sexual and Gender Identity Disorders proposed possible detailed criteria [4]. Also in this case, as for the ICD-11, the clinicians of DSM-5 considered the possible differential diagnosis with paraphilic disorders. Both ICD-11 criteria as putative DSM-5 criteria isolate hypersexuality from paraphilias. However, hypersexuality is not a pathological category of DSM-5 for several reasons, including insufficient evidence, studies or clinical trials on hypersexual subjects, and the potential misuse of this delicate diagnosis in forensic settings [10 15].

Hypersexuality and comorbid disorders

Hypersexuality is very often present along with different comorbid disorders, that make the diagnostic process more complex and question the official nosography. In fact, hypersexual disorder was found in comorbidity with other psychiatric and physical conditions, particularly in males, such as anxiety and mood disorders, substance use disorder, attention-deficit hyperactivity disorder (ADHD) [16-18]. Moreover, some studies , and that hypersexuality correlates with narcissistic, borderline, antisocial, avoidant, obsessive-compulsive, and passive-aggressive personality disorders; a high comorbidity with paranoid personality disorder was also found [16 19].

To make the differential diagnosis, it is necessary to distinguish hypersexuality from paraphilic disorders. Comparing to paraphilias, hypersexual subjects and hypersexual behaviours do not concern inanimate objects, animals, parts of the body, etc. [20]. However, paraphilic patients can also develop hypersexual disorder along with elements of compulsivity, obsession and distress.

Finally, hypersexual behaviours should also be distinguished from other medical conditions, neuropsychi-



The figure shows the sexual activities involved in hypersexuality cases in a deregulated and pathological way.

FIGURE 1. *Sexual behaviours and hypersexuality.*

atric diseases, neurodegenerative disorders and from iatrogenic effects of some medications [4 21].

Treatments

Following the idea of hypersexuality as a mental disorder, some possible treatments can be considered along the pharmacological and psychotherapeutic continua [22]. The first includes the noradrenergic and serotoninergic reuptake inhibitors, or simply selective serotonin reuptake inhibitor [23]. On the other hand, also opiate agonists were experimentally verified for compulsive sexual behaviour in a retrospective study [24]. Psychological therapies for hypersexuality are mainly follow cognitive-behavioural approaches, although psychodynamic psychotherapy focused on trauma and the family of origin have also been considered useful [2]. Moreover, different styles of group or couple therapy were also found to be useful [2 22]. Also mindfulness has proven to be effective in people seeking help for hypersexual behaviour [25]. In any case, it is also important the treatment of comorbid conditions, such as substance abuse, mood and anxiety disorders [2]. This aspect represents a crucial point to take into account for the treatment of hypersexual subjects.

Conclusions

If most of social media recently claimed that "hypersexuality is a mental disorder that regards the compulsive sexual behaviour", based on our article the issue remains controversial. The psychiatric community sees the hypersexuality as a pathological condition, and different psychological treatments were empirically proven. Therefore, many psychiatrists and clinical psychologists prompt to include hypersexuality in the psychiatric nosography, although some doubts still persist. The first doubt concerns the differential diagnosis. Is hypersexuality an isolated disorder? Or the sexual addiction is a consequence of another mental disease, as manic phases of bipolar disorder or the effect of substance abuse? The compulsive sexual behaviour can be considered a psychotic sign or the onset of a first episode of psychosis [26] in the young while an iatrogenic effect of Parkinson's therapy in the elderly [27]. However, these comorbid conditions could be considered into the diagnostic process to detect a primary diagnosis excluding the other consequent pathologies.

In other words, if hypersexuality is not better accounted for by another mental disorder, it could be considered a category *per se*. This is the case of many mental diseases as addiction and eating disorders. In this regard, when two pathologies are present together, we talk of dual diagnosis. Therefore, it is crucial to take into account the concept of dual diagnosis involved also in hypersexual disorder when we adopt a categorial diagnostic method [28].

In conclusion, we believe that when individuals use sex, sexual behaviour and sexual activities as a therapy for another disorder, such as anxiety or depression, that could be considered as an index of discomfort. In the same manner, when a subject suffering from a specific mental disorder, such as bipolar disorder or schizophrenia, the hypersexual behaviour can be considered a manifestation of those primary diagnoses. If APA will include hypersexuality as a disorder, it is important to define a criterion that clearly specifies whether the disorder is present alone or in comorbidity, as it has been partially proposed [4]. On the other hand, many theories and hypothesis try to explain the origin and the correct definition of hypersexuality according to different approaches, although all studies conclude that more research and clinical studies are necessary to be able to categorize hypersexuality as a specific disorder.

Conflict of Interest

The authors declare no conflict of interest.

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