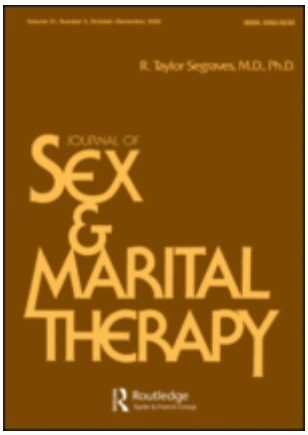

A Treatment-Oriented Typology of Self-Identified Hypersexuality Referrals

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RUNNING HEAD: TYPOLOGY OF HYPERSEXUALITY REFERRALS

A Treatment-Oriented Typology of Self-Identified Hypersexuality Referrals

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Abstract

Clients have been seeking professional assistance to help control hypersexual urges and behaviors since the 19th century. Despite that the literature emphasizes that cases of hypersexuality are highly diverse with regard to clinical presentation and comorbid features, the major models for understanding and treating hypersexuality employ a "one size fits all" approach. That is, rather than identify which problematic behaviors might respond best to which interventions, existing approaches presume or assert without evidence that all cases of hypersexuality (however defined) represent the same underlying problem and merit the same approach to intervention. The present article instead provides a typology of hypersexuality referrals that links individual clinical profiles or symptom clusters to individual treatment suggestions. Case vignettes are provided to illustrate the most common profiles of hypersexuality referral that present to a large, hospital-based sexual behaviors clinic, including: (a) *Paraphilic Hypersexuality,* (b) *Avoidant Masturbation,* (c) *Chronic Adultery,* (d) *Sexual Guilt,* (e) the *Designated Patient,* and (f) better accounted for as a symptom of another condition. Suggestions for fitting each type into the major diagnostic systems are provided.

Keywords: masturbation, sex addiction, sexual compulsivity, sexual disorders, taxonomy

A Treatment-Oriented Typology of Self-Identified Hypersexuality Referrals

Clients have been seeking professional help to control extremely frequent or *hyper-*sexual urges and behaviors since the 1800s (e.g., Krafft-Ebing, 1886; Rush, 1812). Every major school of psychotherapeutic thought has been applied in hopes of understanding such clients' reported distress, sometimes with attempts to reduce the urges/behaviors presented (e.g., Salmon, 1995; Quadland, 1985), and sometimes by reinterpreting the clients' complaint as an internalization of arbitrary social norms about sexuality (e.g., Klein, 2003; Levine & Troiden, 1988) or as an attempt to escape responsibility for their sexual behavior (e.g., Berlin, 2001).

Multiple theoretical models have been asserted in the clinical literature to explain hypersexual behaviors, most frequently the addiction, compulsivity, and impulsivity models (e.g., Barth & Kinder, 1987; Coleman, 2003; Goodman, 2001). These attempts to identify a single underlying feature common to all cases of hypersexuality have oftentimes been asserted ambitiously: In their introduction to *The Sex Addiction Workbook,* Sbraga and O'Donohue (2003) claimed "No matter what the sexual problem is, the causes and treatment are the same" (p. 3, offset in oversized type). Goodman (2001) expressed the idea even more broadly: "All addictive disorders, whatever the types of behavior that characterize them, share an underlying psychobiological process, which I call the addictive process" (p. 207). Despite the numerous comparisons and debates between the various models (e.g., Barth & Kinder, 1987; Berlin, 2001; Coleman & Grant, 2011; Goodman, 2001), no model has yet met with successful outcomes data.

One possible reason for the lackluster evidence for the existing models of hypersexuality is that they all repeat the same mistake: They presume that one size fits all. That is, rather than provide the clinician with a means for identifying the relevant features of an individual client's situation—and, thereby, a means to identify which interventions to consider—the existing

models each suggest a single conceptualization, to be applied no matter what the clinical profile of the actual case.

This assumption of hypersexuality as a unitary phenomenon exists despite that most clinical authors emphasize the diversity of clinical presentations they observe. That diversity, in addition to our own experience with such referrals, suggests a different, if somewhat obvious, idea: There is more than one clinical phenomenon in play, and no single model applies to all clients presenting with or complaining of hypersexuality. This is not to say that all or even any of the existing models are necessarily in error. Rather, what we reject is the (sometimes only implicit) assertion that cases of hypersexuality—no matter how broadly or vaguely defined—all represent the same underlying problem and therefore all merit the same label and approach to treatment. Instead, there appear to be different *types* of hypersexuality referral, with different types better conceptualized (and treated) in different ways, including conceptualizing some cases as factitious. For emphasis, it is the types of hypersexual *referral* being described here, as some proportion of these cases are not meaningfully called 'hypersexual' at all.

There have been exceptions to the presumption that hypersexuality represents a single phenomenon (see Orford, 1978), with authors emphasizing different features to describe the clusters they perceive among hypersexuality referrals. One such exception is Levine (2010), who was arguing against a proposal to add *Hypersexual Disorder* to the DSM-5 (Kafka, 2010), which, as of this writing, is under consideration for inclusion in the DSM-5 appendix. In his chart review, Levine considered cases referred for or self-labeled with sexual addiction and divided them into: (a) no sexual excess beyond breaking the spouse's restrictive rules, (b) discovery of husband's longstanding sexual secrets, (c) new discovery of the joys of commercial or chat room sex, (d) the bizarre or paraphilic, (e) a different concept of masculinity, and (f)

spiraling deteriorating dependence of commercial or illegal sex. Although Levine acknowledged that his distinctions were arbitrary, his descriptors suggest that his typology was based on a combination of enduring features of the client (e.g., paraphilic interests) and whatever immediately precipitated the referral (e.g., wife's discoveries) to demarcate the types.

Another exception to the presumption of hypersexuality as unitary was, if ironically, contained in the DSM-5 proposal itself (Kafka, 2010). Although it might not have been the intent of the proposal's author, the set of diagnostic specifiers proposed: (a) masturbation, (b) pornography, (c) sexual behavior with consenting adults, (d) cybersex, (e) telephone sex, (f) strip clubs, or (g) other—also delineates a typology, one based on the hypersexual behaviors themselves to demarcate the types.

Coleman also described hypersexuality as manifesting in multiple types and subtypes. Initially referring to it as Compulsive Sexual Behavior, Coleman (1992) divided clients' presentations first into (a) paraphilic compulsive sexual behavior, and then subdivided the non-paraphilic presentations into: (b) compulsive cruising or multiple partners, (c) compulsive fixation on an unattainable partner, (d) compulsive autoeroticism, (e) compulsive multiple love relationships, and (f) compulsive sexuality in a relationship. Subsequently, Coleman (2011) expanded that formulation, adding (g) compulsive use of erotica and (h) compulsive use of the Internet for sexual purposes, and relabeling the overarching phenomenon as Impulsive/Compulsive Sexual Behavior. Thus, the Coleman typology partly resembles the Kafka typology in using the hypersexual behaviors themselves to demarcate types (i.e., masturbation/autoeroticism, pornography/erotica use, and Internet-mediated sexual activity), but also includes the client's romantic relationship context to demarcate other types (i.e., cruising to

attain multiple sexual partners, maintaining multiple love relationships, and compulsive sexual activity within a single romantic relationship).

As did Levine (2010), the typology presented here divides cases "according to perceived essential similarities" (p. 206). (This is unlike a *taxonomy,* wherein the categories, or *taxa,* are established on the basis of distinct etiologies—although the types presented here may ultimately prove to be etiologically distinct from each other, there are few data to support that assertion as yet.) There are, of course, many features that one might deem to be the essential ones. The present typology employs an explicitly *treatment-oriented* approach. That is, we differentiated types so as to maximize their utility in selecting from among the options for intervention.

Despite continuing debate over conceptual models, authors have been coalescing on broad, but very similar suggestions for treatment. It is repeatedly recommended that clinicians employ a multi-faceted or multi-model approach, tailored to individual clients' needs: anti-androgens for their anti-libidinal effects, SSRIs for their anti-compulsive/impulsive effects, cognitive-behavioral techniques for relapse prevention, couples' counseling, motivational interviewing, and, in some cases, psychoeducation about human sexuality without any systematic therapy at all (Coleman, 2003; Kafka, 2007; Kaplan & Krueger, 2010; Kingston, in press; Kingston & Firestone, 2008). Lacking from the literature, however, is any guidance for matching the widely varying clinical presentations to those potential interventions. That is, although there appears to be some consistency in the family of treatments to consider and in the recognition of a diversity of presentations, the literature does not provide more specific recommendations for which of the many presentations suggest which of the many potential treatments. The present article therefore presents a clinical typology for clients who present with or complain of

hypersexuality, using suggested treatments as the basis for classification. (Detailing the contents of the treatments themselves is, however, outside the present scope.)

To illustrate the typology, the following series of case studies were selected from those cases attending the Sexual Behaviours Clinic (SBC) of the Centre for Addiction and Mental Health (CAMH; Toronto, Canada)—a large, interdisciplinary, mental healthcare facility and teaching hospital of the University of Toronto. By being part of the Canadian public healthcare system, prospective clients experience no out-of-pocket expenses or other financial barriers to clinical services; thus, clients of the SBC may represent a wider demographic range than is available to most private clinics.

The SBC is a tertiary, rather than a primary, care provider—It provides clients with specialized clinical (sexological) services that are usually unavailable from general care providers. Clients receive appointments upon referral by a licensed physician, such as a psychiatrist, family practitioner, or walk-in clinic. Thus, although many physicians will provide a referral upon request, an initial screening process can be imposed. The SBC receives referrals and consultation requests pertaining to the full range of sexual phenomena, of which hypersexuality referrals represent a subset. The cases included in this article all were assessed by or under the clinical supervision of the first author.

Types of Hypersexuality Referral

Paraphilic Hypersexuality

Approximately a third of the hypersexuality referrals to the SBC exhibit a profile we call *Paraphilic Hypersexuality,* which has two key features: First, persons of this type report extremely high frequencies of one or more sexual behaviors, sufficient to lead to distress. Such behaviours have included: chronic adultery, several hours per day viewing pornography or

seeking sexual partners over the Internet, and very frequent solicitation of prostitutes. Second, persons of this type report multiple, but often low-grade or subclinical, paraphilic interests. On initial presentation, the client (or the care provider who referred the client) often emphasizes only the frequent behaviors and neglects the paraphilic interests. In our experience, however, clients are quite forthcoming about those interests, once prompted by the clinician.

CASE 50 is a 33-year-old male referred after he was seen in a hospital emergency room, presenting with depression, agitation, and suicidal ideation, following his girlfriend's discovery of his sexual interests. The client reported he is "obsessed with sex" and has a "sex addiction." He indicated that he spends more than half of every day thinking about sex and that he has been "leading two different lives"—one with his girlfriend and one with his other sexual partners. He reported masturbating up to five times per day (two to three, on average), having called chat lines for phone-sex two to three times per week, and not having been faithful to any of his girlfriends since adolescence.

The client reported that his sexual urges have led him to view pornography on his work computer and to leave work early to meet a partner for a sexual encounter. He indicated he has never been caught for either, however. He added that he feels low about himself after his episodes of infidelity and volunteered that he uses sex both as a way to regulate negative emotions and to reward himself for accomplishments.

With respect to the type of person to whom he is sexually attracted, the client said, "I'm embarrassed to say this, but anything with two feet and a heartbeat." He reported no specific sexual preferences with respect to the physical characteristics of his sexual partners (such as breast size, hair color, or ethnicity), endorsing a strong erotic interest in women and some interest in men, but also a substantial erotic attraction to persons

who are female in appearance, with fully developed female breasts, but also with a functioning, fully developed penis on the otherwise feminine-appearing body.

With respect to his sexual activity interests, the client said, "The more adventurous, the better." He reported an interest in having sex in public places, including parks, parking lots, and nightclubs. He indicated that he does not believe that he truly wants to be caught having sex in these public places, but that he likes the thrill that accompanies the risk. He reported that he also has an interest in covertly viewing others having sex. He reported creeping up to the windows of certain hotels where prostitutes are known to take their clients, in order to watch the couples having sex. In one incident, he intended to solicit a specific prostitute he knew, but found that another customer had hired her before he could—So, he instead covertly followed them to watch them having sex.

The client reported that he similarly enjoys viewing pornography of persons who are unaware of being recorded and that he has made video recordings of his own sexual encounters, both with and without his partners' knowledge. He reported that he has never publicly distributed these, but that he enjoys masturbating to them. His sexual repertoire also includes erotic asphyxiation, wherein he and his partner choke one another with their hands or arms. He does not engage in erotic self-asphyxiation, however. The client acknowledged he enjoys masturbating while wearing women's underwear, but reported no arousal to the thought of himself as woman, noting instead that his arousal is associated with the undergarment itself.

Case 50 illustrates both key features of this type of referral: an extreme frequency of one or more sexual behaviors (adultery, solicitation of prostitutes, and masturbation) and multiple paraphilic interests (voyeurism, fetishism, etc.).

Although Paraphilic Hypersexuals often report that very many stimuli can sexually excite them, some speak rather tentatively in relating their interests, referring to some as historical or transient. Many Paraphilic Hypersexuals also appear to lack the strong, internal directedness that most men report regarding their sexual interest(s). Instead, Paraphilic Hypersexuals will report testing out or going along with a partner's sexual interests, but neither with the enthusiasm expressed by typical paraphilic men (i.e., paraphilic men without hypersexuality), nor with the revulsion that *euphilic* (i.e., non-paraphilic; Cantor, 2011) men would express when confronted with the concept. One case reported that he habitually visits websites that provide long lists of paraphilic genres, viewing their contents simply in their alphabetic order, masturbating to all of them, reporting that he finds sexual situations *in general* to be arousing. Unlike typical paraphilic men—who express (and sometimes embellish over a lifetime) rigidly specific interests—Paraphilic Hypersexuals sometimes appear very non-specific in their interests.

Very frequent solicitation of prostitutes is a common (but not universal) component of this type of referral. Because other types of hypersexuality also solicit prostitutes frequently, such solicitation *per se* does not identify a case as belonging to this type. Interestingly, many Paraphilic Hypersexuals' descriptions of their interactions with prostitutes or erotic dancers include an attraction or desire to become a part of the sex workers' milieu:

> *CASE 81 is a 30-year-old male referred for assessment for "addiction to pornography, masturbation, and strip clubs." He reported sexual interests in urophilia, coprophilia, and hebephilia*[1] *and having spent more than $11,000 hiring lap dancers and strippers to*

urinate on him or let him penetrate them anally with his finger; however, he reported that the most satisfying activity for him was being able to go out for cigarettes with the strippers after the aforementioned activities: He described its significance as "I've conquered just being a customer."

Some cases have expressed that they feel a sexual charge from, or a draw to, the unseemly environment or illicit nature of street prostitution. Such expressions have also included the desire to prostitute themselves, which often evaporates when the person discovers that the reality fails to measure up to the fantasy. Other cases have reported taking on prostitutes as "projects," and some date prostitutes nearly exclusively.

Many Paraphilic Hypersexuals appear to be characterized by a desire for novelty, both in pornography and in sex partners—a desire that itself can appear to have a paraphilic intensity. Kurt Freund described a potentially related phenomenon. His observation emerged from his work with a specific set of paraphilias (exhibitionism, voyeurism, toucherism/frotteurism, and paraphilic rape) which he theorized were subtypes of a single, superordinate problem he labeled *Courtship Disorder* (Freund, Seeley, Marshall, & Glinfort, 1972). "In cases of disordered courtship behavior, a high degree of novelty of object is sought, and the anomalous pattern is basically never acted out towards persons with whom there already exists some kind of social relationship" (Freund, 1976, p. 186). Although Paraphilic Hypersexuals demonstrate a wide range of paraphilic interests (not limited to those that comprise Courtship Disorder), Paraphilic Hypersexuals may represent another manifestation of a paraphilic interest in novelty or, as Freund phrased it, "an erotic preference for strangers" (Freund & Watson, 1990, p. 593).

One remarkable feature of Paraphilic Hypersexuality is that a sizeable number of such persons report *gynandromorphophilia,* a rarely discussed erotic interest in persons with both

male and female anatomy (typically, full breasts and an intact penis), such as possessed by incompletely transitioned male-to-female transsexuals (Blanchard, 1993; Blanchard & Collins, 1993; Money & Lamacz, 1984). Although typically describing themselves as heterosexual, Paraphilic Hypersexuals often report seeking out pornography or entertaining sexual fantasies involving *"she-males,"*[2] and many have had sexual contact with such persons (or with intact biological males), although others have limited themselves to sexual fantasy and pornography. In many cases, the enduring (if low-intensity) erotic interest in she-males or males has led Paraphilic Hypersexuals to confusion about their sexual orientation or gender identity, sometimes hesitating when describing themselves and referring to themselves hesitatingly as "mostly heterosexual" or, sometimes, as bisexual. Indeed, it would be interesting to speculate what portion of men who refer to themselves bisexual might also be gynandromorphophilic (with or without Paraphilic Hypersexuality).

Suggested interventions. There is little evidence to support any method of changing paraphilic interests into euphilic interests. Rather, treatment suggestions for persons with paraphilic interests include lifestyle integration (for interests that can be expressed alone or with consenting partners) and harm reduction (for those interests that cannot). It is outside the scope of the present article to outline such interventions, but the Internet has permitted persons with even the rarest of sexual interests to form communities for support, for political advocacy (of all stripes), and for social and sexual networking. Because Paraphilic Hypersexuals describe less rigid (or, perhaps, more exploratory) sexual interests than do paraphilic men without hypersexuality, it remains unknown to what extent that the array of interests might be modifiable (unlike paraphilic men without hypersexuality).

It is for the Paraphilic Hypersexuals that the aforementioned recommendations for medications may be the most relevant. Selective serotonin-reuptake inhibitors (SSRIs) have been reported to reduce both libido and impulsivity, but can also delay or entirely prevent ejaculation (e.g., Corona et al., 2009), leading men to seek greater stimulation to trigger orgasm. Endocrinological agents (anti-androgens) also reduce libido—potentially more effectively than do SSRIs—but have a less tolerable side-effect profile (for a review, see Saleh & Berlin, 2003). "Chemical castration" with such agents is rarely recommended outside a forensic context.

Conventional diagnostic systems. DSM-IV-TR includes code 302.9 *Sexual Disorder Not Otherwise Specified* (NOS) and code 302.9 *Paraphilia Not Otherwise Specified* (NOS). *Sexual Disorder NOS* indicates "a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia" (American Psychiatric Association, 2000, p. 582), and provides as an example "distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used" (p. 582). Because *Sexual Disorder NOS* excludes the paraphilias, that diagnosis would appear to exclude Paraphilic Hypersexuality; however, the source of such clients' distress is not necessary the paraphilias themselves, but the frequency of their expression. Moreover, Paraphilic Hypersexuals typically show both paraphilic and euphilic behaviors. Thus, *Sexual Disorder NOS* may nonetheless apply. *Paraphilia NOS* does not pertain to frequency of sexual behaviors; rather, it captures paraphilic interests that do not have DSM codes of their own. Thus, Paraphilic Hypersexuals may receive multiple diagnoses of *Paraphilia NOS* (in addition to any paraphilic interests that have their own codes). Also relevant is code 313.82 *Identity Problem,* which applies in cases of uncertainty about sexual orientation, sexual behavior, moral values, etc. Such a classification would be particularly relevant when the goal of

therapy is to integrate the client's sexual interests into his life. The criteria for Hypersexual Disorder currently under consideration for the DSM-5 appendix also exclude paraphilic behaviors (Kafka, 2010). The proposal does makes explicit that hypersexuality and paraphilia(s) can be comorbid, however. The current *International Classification of Diseases* (ICD-10; World Health Organization, 1992, 2009) contains F52.7 *Excessive Sexual Drive* and F65.6 *Multiple disorders of sexual preference* to denote the many paraphilias. "Sometimes more than one abnormal sexual preference occurs in one person and there is none of first rank" (World Health Organization, 2009, p. 352).

Avoidant Masturbation

The next largest subset of hypersexuality referrals received by our clinic is characterized by what appears to be *Avoidant Masturbation.* The presenting complaint from such individuals, thus far exclusively men, is their expending inordinate amounts of time viewing pornography and masturbating. Although there does not exist any clear boundary between healthy and pathological amounts of masturbation, the persons in this category report masturbating several hours per day, having been fired from jobs for seeking online pornography or masturbating during work hours, failing classes, and forgoing other major life activities (such as social relationships or hobbies) to spend the time masturbating.

Unlike the Paraphilic Hypersexuals (many of whom also report extreme frequencies of masturbation), persons who engage in Avoidant Masturbation report little, if any, paraphilic interest. Upon interview, they report seeking conventional pornography, often involving women with large breasts, three-way sexual encounters, and conventional sexual role-playing (doctor-nurse, etc.). Although some Avoidant Masturbators report an interest in mild and consensual

bondage or discipline, the level of their interest in unconventional activities is far lower than that of the wide-ranging, more frankly paraphilic interests of the Paraphilic Hypersexuals.

Like Paraphilic Hypersexuals, some Avoidant Masturbators report a preference for novelty; however, the level of motivation for novelty among Avoidant Masturbators also appears to be much less intense. It is not clear whether the desire for novelty in erotic images represents the same phenomenon as the desire for novelty in sexual partners, differing only in extent.

CASE 78 is a single, 22-year-old male, referred for an assessment of "an Internet pornography addiction." He reported that he spends 4–5 hours daily viewing Internet pornography, but that he is not sure he actually has a problem. He started viewing Internet pornography when he was 14 and currently masturbates 1–3 times per day. The client has been in two serious relationships and reported that his pornography use remained relatively consistent regardless. He reported that he "cannot look at the same thing more than once" and that seeking new images and videos takes up the majority of the time he spends masturbating. The client also stated that his pornography use sometimes gets in the way of his schoolwork and that he has been 10–15 minutes late to meetings because he was masturbating.

The client stated that when he wants to look at pornography, he must *do so, finding it difficult to postpone gratification. He believes his pornography use is a "procrastination tactic" that he uses to avoid doing schoolwork or housework. He added he now feels tired of being disappointed in himself and feels that he is "stuck in a rut," with no follow-through for important activities. The client noted repeatedly that he has difficulty delaying gratification in any sense, not only for masturbation but also for*

buying himself things or engaging in other enjoyable activities. He reported he finds it difficult to deny himself things that he wants, in general.

Very many of the men who report schoolwork or employment problems brought on by extreme masturbation frequencies acknowledge or even volunteer that they masturbate to avoid a task or chore. Interestingly, the link between masturbation and procrastination has not gone unnoticed by the public: The *Urban Dictionary* (www.urbandictionary.com) contains an entry for *procrasturbation*, an amusingly accurate portmanteau of *procrastination* and *masturbation*. Many Avoidant Masturbators report feelings of anxiety or dysthymia: Whereas some report using masturbation to soothe such emotions, others report that masturbation instead results in anxiety or depression.

Upon interview, many Avoidant Masturbators describe having previously and repeatedly attempted to reduce their time spent masturbating. Such attempts have included (often with the support and assistance of their romantic partners) parental controls on computers, removing computers from their home, and attendance at 12-step-based self-help organizations (such as Sex and Love Addicts Anonymous). Some clients have reported that their desperation has led them to consider sex-drive reducing medications, such as SSRIs.

Remarkably, Avoidant Masturbation has not, at least among our referrals, always interfered with the clients' frequency of or satisfaction with their sexual activity within their romantic relationships. Some Avoidant Masturbators have reported participating in enjoyable activity with their partners *in addition to* their masturbatory outlets, whereas others have reported having little interest in sex with their partners *in favor of* masturbation with pornography.

We use the term "avoidant masturbation" because masturbation appears to be the most common behavior associated with this syndrome; however, other low-investment sexual

behaviors can also be used for procrastination or avoidance. Within the gay male community, many continuous hours can also be spent frequenting bathhouses, perusing online hook-up sites, engaging in *Cybersex,* and engaging in live sexual activity with very high numbers of partners. That is, although masturbation is not always the actual behavior in such cases, the sexual behavior is nonetheless being employed for avoidance, and the same approach to treatment may prove useful.

Suggested interventions. When confronted with extreme rates of masturbation, clinicians often apply means to block or prevent the behavior(s), such as with the parental controls on home computers. For Avoidant Masturbation, however, it may be more productive to address the avoidance, rather than the masturbation. It is for this type of hypersexuality referral that existing suggestions for motivational interviewing techniques would seem the most applicable (e.g., Del Giudice & Kutinsky, 2007; Kingston & Firestone, 2008; Orzack, Voluse, Wolf, & Hennen, 2006). Similarly, interventions aimed at procrastination itself may also be of use. As with Case 69, there exist many behaviors (especially Internet-mediated behaviors) that can be used to escape less enjoyable activities, and symptom substitution can occur.

Conventional diagnostic systems. The DSM-IV-TR does not explicitly mention time spent masturbating among the examples for which the clinician might apply code 302.9 *Sexual Disorder NOS;* nor does the manual exclude it. Thus, *Sexual Disorder NOS (Extremely Frequent Masturbation),* or similar, would appear to apply. The term *Sexual Disorder NOS (Avoidant Masturbation)* would be more specific, but that term also indicates the mechanism motivating the behavior, whereas the DSM-IV-TR aims to be atheoretical. The occurrence of the term "excessive masturbation" in the literature suggests *Sexual Disorder NOS (Excessive*

Masturbation); however, "excessive" suggests that there is an acceptable range that is being exceeded, whereas no such range exists.

A similar approximation is code 312.3 *Impulse-Control Disorder NOS:* "This category is for disorders of impulse control…that do not meet the criteria for any specific Impulse-Control Disorder or for another mental disorder having features involving impulse control described elsewhere in the manual (e.g., Substance Dependence, a Paraphilia)" (American Psychiatric Association, 2000, p. 677). If one accepts that individuals self-referring for Avoidant Masturbation suffer harm, then Avoidant Masturbation would seem to fit the overarching description of impulse-control disorders in DSM-IV-TR: "the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others" (p. 663).

Avoidant Masturbators would appear to meet the criteria for Hypersexual Disorder that are under consideration for the DSM-5 appendix, with two relevant specifiers: masturbation and pornography use. Among the Avoidant Masturbation cases that present to our clinic, however, any distinction between masturbation and pornography use appears moot: It is extremely rare to encounter cases who very frequently masturbate without pornography or who view large amounts of pornography without masturbating. Although the two behaviors are dissociable, they may be redundant in practice.

The ICD-10 includes "excessive masturbation" under code F98.8 *Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence* (World Health Organization, 2009, p. 371). To repeat an earlier point, however, the word "extreme" might be more appropriate than "excessive."

Chronic Adultery

Our clinic receives more referrals fitting the Paraphilic Hypersexuality and Avoidant Masturbation profiles, yet the type that appears to be the most widely discussed in the public media is what we call *Chronic Adultery.* Although some Paraphilic Hypersexuals also have cheated on their spouses, the Chronic Adulterers (almost always, if not always, male) lack significant paraphilic interests and instead report unremarkable use of sex toys, costumes, or mild (mostly symbolic) bondage. Although the Chronic Adulterers are (essentially by definition) outliers regarding the *frequency* of cheating on their spouses, they lack the extreme amounts of *time* spent engaging in or seeking out sexual gratification. Avoidant Masturbation is the reverse: Such persons expend extreme amounts of time, but do not appear to cheat on their spouses significantly more frequently than population/cultural baserates. The extramarital activities described by Chronic Adulterers have included one-time encounters, on-going sexual relationships, and solicitation of prostitutes. Chronic Adultery would not, however, describe openly non-monogamous or similarly non-traditional relationships wherein no agreement is violated, nor to situations of a single, on-going or long-term extramarital relationship, despite that it included many episodes of sexual behavior.

> *CASE 74 is a 47-year-old man, heterosexually married for 15 years, with two children. He was referred by his family physician following his request for assistance with his high libido, infidelity, and "sexual addiction." The client reported that he has cheated on his wife "dozens of times," all with different women, and that he would masturbate two to three times daily.*
>
> *According to the client, there is a large discrepancy between the frequency and type of sexual activity he and his wife desire; however, he stated that he loves his wife,*

finds her sexually attractive, and "If that's where I can get [sex], then that's where I want it." He reported he would like to have sex daily; whereas, he believes she "could go forever without sex." He reported that he and his wife have sex approximately three times per month. He stated that she has never masturbated, has never viewed sexually explicit materials, and is not comfortable engaging in anything other than procreative sex. He reported that his wife has been the victim of sexual abuse in the past, which he believes contributes to her inhibition around sexual activities. The client stated that he hopes that he and his wife can come to a compromise regarding their frequency of sexual activity, but that a compromise may be impossible because of his "sexual addiction."

The client reported that during his twenties he dated one to three women simultaneously, always having overlap among his relationships, and he admitted he has never been faithful to any relationship. He reported that prior to his marriage he was repeatedly "juggling" multiple, simultaneous relationships with women.

As with Case 74, a Chronic Adulterer will very often report that his wife does or has suffered from some situation that interferes with her enjoyment of sexual activity. These situations have included: coital pain disorders (i.e., dyspareunia); low, or a dramatically lower, libido; a history of having suffered sexual abuse; and a conservative or religious background.

Typically, only the client, rather than the couple, presents for assessment; thus, only the perspective of the client (and not his partner) is directly available. Because these cases occur within highly conflicted marital situations, one is naturally wary of the accuracy and completeness of the clients' portion of the story; however, to the extent that the wives' perspectives have become available (such as by the couple subsequently attending the clinic together for marital/relationship counseling), the wives' histories and levels of sexual interest

have matched their husbands' descriptions of them. (Relatedly, it has also been our experience that the clients can be more forthcoming with the therapist than with their spouses, such as by revealing more violations of the marriage to the therapist than to their wives.)

The mainstream media regularly display celebrities who profess "sexual addiction" as the explanation for their infidelity, suggesting an obvious point: There exist men who may seek treatment, not to attempt to change their behaviors, but for the secondary gain of seeming to make such attempts in the eyes of the public or of their spouses and families. Although such cases undoubtedly exist, the Chronic Adulterers attending our clinic appear to do so in the absence of such a context. These have included cases who, for example, were referred during the height of marital discord, but by the time of the appointment, had separated and decided on divorce—yet with the husband nonetheless attending the appointment, on his own, expressing the desire to understand his own behavior and not to destroy any potential for a successful (monogamous) relationship with someone else in the future.

Although it is rarely made explicit, both public and professional discussions of chronic adultery frequently devolve into frankly judgmental discussions about ethical/moral implications of the adultery and about sympathy for the plight of the wives, with generalizations made from a single (often celebrity) example to all cases of chronic adultery. In practice, however, cases of Chronic Adultery have presented to our clinic at every level of seeming blameworthiness:

> *CASE 70 reported that he does not want his wife to find out about his affairs. When asked what he hopes to get out of this assessment, the client stated that while he has no intention of leaving his wife, he is still unsure whether he is willing or able to stop having sex with other women. He stated that his wife did not make him come to this assessment and that he sought the referral from his physician in order to better understand his*

problem. The client stated that he does not know whether he would want to engage in individual treatment and that couple's therapy is out of the question. The client asked for recommendations for books or articles to help him understand why he feels the need to have sex with multiple women.

The willingness of Case 70 to actively deceive his spouse differs strongly from cases wherein the adultery compensates, or appears to be aimed at compensating, for discrepant libidos between the partners.

CASE 62 is a 51-year old male referred for assistance in ending his solicitation of prostitutes, which has increased from once or twice per month to 1–3 times per week. His wife suffers from dyspareunia (genital pain upon intercourse), and they have not had any sexual contact with each other in the past 18 months. When asked what he hopes to get out of this assessment and possible psychotherapy, the client stated that he would like not to have the urges and desires he currently has, and wishes his sex drive were lower so that he could be satisfied with the sexual relationship he has with his wife. He would like to never have sex with a prostitute again and wishes that his wife wanted to have sex with him. He stated that he could be okay with not having vaginal intercourse with his wife if she showed more sexual interest in him. He reported that his wife is very attractive and that he is very attracted to her, but wishes she felt that way about him.

The behaviors of the two previously mentioned types—Paraphilic Hypersexuality and Avoidant Masturbation—are often reported to interfere with marital relationships. In Chronic Adultery, however, the marital difficulties often seem to cause or exacerbate a pre-existing sexual problem.

Suggested interventions. It is this type of hypersexuality referral for which couples' therapy is indicated. Indeed, many aspects of the issues addressed in therapy often appear

unassailable without the partner. Unfortunately, this type of referral has nearly always attended individually, with a charge from the wife to fix *his* problem (e.g., his addiction). We have not found interventions aimed solely at the husband to be productive, however. Despite the wide variety of marital situations and marital difficulties, what appears to be common across these cases is that one partner (thus far in our experience, the husband) employed a problematic strategy to address *the couple's* problematic situation. Discrepant sex drive is very familiar to relationship therapists. Among Chronic Adulterers, the atypically high and atypically low levels of sex drive often predate the relationship—although the heightened sexuality early in relationships could plausibly delay the salience of the discrepancy to each partner. Instead of addressing the discrepant sex drives directly, however, the Chronic Adulterers have expressed their high sex drives outside the relationship, on a long-term basis.

To the extent that the perspectives of the wives of Chronic Adulterers have become available directly, they have been remarkably ambivalent. As noted already, the women in these relationships typically report (or are reported to have) a history or long-standing condition interfering with their desire to engage in sex. A possibility that is very difficult—but nonetheless worthwhile—to explore is the extent to which the wives may experience *relief* from the pressure to satisfy the sexual needs of their partner, once he has begun to satisfy those desires outside the relationship. Although the common insistence from the wife is that the husband attend therapy in order to fix his problem, that demand also serves to distract from or to excuse unaddressed issues on the parts of the wives. Unfortunately, in practice, the husbands' history of deception serves to (or is used to) block discussion of any potential contribution on the part of the wife to the marital context. Such situations require great caution in therapy, as this distinction can easily be mistaken for victim-blaming.

Conventional diagnostic systems. Within the DSM-IV-TR, Chronic Adultery is probably more accurately described by V61.10 *Partner Relational Problem* than by 302.9 *Sexual Disorder NOS* (i.e., "succession of lovers…"). Although the Chronic Adulterer has typically had such a succession of sexual partners, the distress appears more attributable to the marital relationship than to the number of sex partners. Moreover, it is not the number of sex partners that appears to be extreme—it is the number of specifically *extramarital* partners that does. A DSM-IV-TR diagnosis of *Partner Relational Problem* is also much more closely associated with the treatment recommendation (couples' counseling) than is *Sexual Disorder NOS,* which is not associated with any specific intervention. As of this writing, the DSM-5 has not released any equivalent categories. The ICD-10 contains "Relationship Disorder NOS" under F68.8 *Other specified disorders of adult personality and behaviour* (World Health Organization, 2009, p. 353).

Sexual Guilt

In the three aforementioned situations—Paraphilic Hypersexuality, Avoidant Masturbation, and Chronic Adultery—clients report distress related to sexual behavior(s) they express with extreme frequency. Other clients similarly present with self-labels of hypersexuality (etc.) and similarly report great distress (often sufficient to have warranted previous diagnoses of depression), but lack any overt, behavioral extremes. The reported frequencies of sexual behaviors—masturbation, coitus, adultery, pornography use, etc.—are well within peer group norms. Indeed, some cases report unusually low rates of some behaviors, including a man who never had sexual intercourse with his wife of eight years (or anyone else) and complete abstinence from masturbation. These cases typically report having been raised in highly conservative (usually religious) environments; however, some cases have willfully adopted

moralistic standards during adulthood, sometimes exceeding the dictates of their religious affiliations. We refer to such cases as *Sexual Guilt.*

CASE 83 is a 40-year-old female, heterosexually married for nine years, with historical diagnoses of Obsessive-Compulsive Disorder and chronic fatigue syndrome. She was referred by her counselor for concerns about "sexual addiction." The client reported that she thinks about sex frequently and that, if she had the energy, she would like to have sex on a daily basis. She reported she masturbates with a vibrator approximately twice per week and only when her husband is not at home, because she is concerned he would feel hurt if he knew she masturbated and experienced orgasms with the vibrator, but not during intercourse with him.

She reported she experiences intrusive thoughts of having intercourse with "whoever is on my mind," noting that she will have thoughts of passionately kissing and having sex with men that she sees throughout her day. She reported that she feels guilty about these thoughts and that she hates them because they involve men other than her husband. The client reported that she has been faithful to her husband, although she has been tempted to cheat.

She reported first having engaged in sexual intercourse at age 15 with her boyfriend at the time and having a total of ten sexual partners in her life. She reported she enjoys passionate kissing, receiving oral sex, and vaginal intercourse. She indicated no paraphilic sexual interests. She reported feeling "bad" about her own enjoyment of cunnilingus as she does not enjoy performing fellatio. She described sex as satisfying, but reported she is unsure if she experiences orgasm, indicating that she feels a "release" but that she is not sure if this is an orgasm because she does not lubricate at that time.

The client reported that she began masturbating approximately five years ago, when she first got her vibrator. The client had difficulty discussing her practice of masturbation, indicating that she finds "the m-word" dirty and feels guilty about her use of the vibrator.

A substantial proportion of cases of Sexual Guilt have previously presented to other clinicians and carry current or historical diagnoses of *Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Anxiety,* or a mood disorder.

Rather than being predominantly or entirely male, both men and women have presented to our clinic complaining of hypersexuality, but describing Sexual Guilt instead. Most such cases express their anxiety broadly, in terms of all sexual urges or interests; however, we also receive cases who express anxiety with regard to only a subset of the stimuli they find sexually arousing. Such cases include persons who chastise themselves for sexual fantasies that are stigmatized, but nonetheless conventional, such as fantasies about an acquaintance or other non-marital partner. Relatedly, this type of case includes gay men who reject or resist their sexual orientation and seek treatment to control what they call their addiction/compulsion/impulses to have sex with men. (Although the same principle would apply to lesbians, no such case has come to our clinical attention.) Sexual Guilt would also describe the analogous situation of persons with uncomplicated paraphilias (i.e., paraphilias without hypersexuality), such as erotic cross-dressing or sexual masochism, similarly rejecting their genuine sexual interests.

The above situations—Sexual Guilt following from anti-sexual attitudes, from internalized homophobia, or from internalized antipathy towards one's own paraphilias—could reasonably be deemed distinct types of hypersexuality referral or distinct subtypes of Sexual Guilt. That is, one could reasonably assert than distress following sexual fantasies about non-

marital partners is of a different type from distress following internalized homophobia. They are included in the same type here, however, because they both suggest the same intervention strategy, consistent with the present treatment-orientation.

Suggested interventions. It is for cases of Sexual Guilt that the interventions most indicated are psychoeducation and permission-giving. In practice, however, the clients' inaccurate beliefs about sexuality (and peer norms) are often attached to multiple other aspects of their belief systems. Although this is sometimes an explicitly religious system (or is merely attributed by the client to his or her religious system), it has also included other deeply held ideologies, such as the roles of men and women or new age beliefs about the benefits of abstinence from any, or several of multiple, pleasurable activities.

Conventional diagnostic systems. Despite the labels such clients have applied to themselves, neither code 302.9 *Sexual Disorder NOS* nor code 312.3 *Impulse-Control Disorder NOS* of the DSM-IV-TR appears appropriate. Nonetheless, such clients' distress is genuine, and other diagnoses may pertain, such as an anxiety disorder or 313.82 *Identity Problem.* In the ICD-10, F60.6 *Anxious Personality Disorder* can apply when the distress includes, rather than is limited to, sexual behavior.

The Designated Patient

A sizeable number of referrals are instigated, not by the client, but by the client's romantic partner. In some instances, such instigation follows from the partner's discovery of the client's infidelity or paraphilic behavior, but in other instances, the partner's demands reflect highly restrictive sexual beliefs, such as a zero tolerance for masturbation, pornography, or non-procreative sex. We commonly refer to this latter presentation as the *Designated Patient.*

CASE 66 is a 51-year-old father of two children, currently residing with his wife. He was referred by his family physician, following concerns expressed by the client's wife regarding the client's use of pornography. He noted he views pornography in the form of magazines or videos, every couple of years, for up to approximately an hour per week. This has reportedly resulted in marital discord: The client indicated that his wife has always expressed a strong opposition to the use of any pornography, telling him he "should have no need or no use for it because I have her." At his wife's request, he disposed of all his pornography when they first began dating and promised her that he would not view pornography again; however, the client reported that he has broken this promise numerous times over the course of their marriage, which has led to significant distrust.

The client reported that he no longer uses the Internet, at his wife's request, as she believes he would use the Internet to view pornography; however, the client reported that his wife nonetheless continues to believe that he is viewing pornography. The current referral was precipitated by his wife observing the client viewing an image which she believed to be pornographic (but, according to the client, was not). She subsequently approached their joint family physician to express her concerns, resulting in the present referral. No concerns about adultery or any paraphilic content of the pornography were expressed by the referring physician, the client, or (reportedly) his wife.

This profile was also recognized by Levine (2010), who described such situations as "No sexual excess beyond breaking the spouse's restrictive rules" (p. 266).

Despite that these clients are called sex addicts (etc.) by themselves or by some of their healthcare providers, our experience with this subgroup is that they lack any of the behavioral

extremes that other types of case present. Numbers of sexual partners (lifetime or current), frequency of masturbation, duration of masturbation, and frequency of intercourse are generally unremarkable. Indeed, their sexual outlets often appear low relative to the clients' age, sex, and cultural background—and can even suggest that the client possesses an exceptional ability to control his sexual urges, never mind an inability to do so.

Typically, only the client (and not the client's partner) attends for the assessment. Indeed, the client often volunteers that the partner made explicit the belief that the problem is specifically the client's problem to solve. This creates the obvious situation that the client may be exaggerating the partner's zero tolerance; however, to the extent that the partners have subsequently attended for couples' therapy and provided their own account, they have confirmed that the expectation was indeed zero tolerance for masturbation or pornography use.

> *CASE 12 is a 66-year-old male. He reported that he and his wife have sex less frequently than once per year and that the last time he approached his wife sexually, she "rolled her eyes and said 'Do we have to continue to do this?'" He reported that she has limited their intimacy to "two hugs per day." He said that, for him, sex is a way to connect to his partner, noting "I would be happy if I could have sex with my partner once per month." The client reported that his partner has never approved of his use of pornographic materials and that she believes in feminist ideals including that women should not be objectified and that the term "wife" is possessive and therefore inappropriate, etc. This has increased his distress over his use of pornographic materials. According to the client, because of his guilt and his partner's urging, every two to three years he has purged all his pornographic materials (i.e., videos, magazines, website bookmarks).*

Suggested interventions. In Designated Patient cases we have found several interventions to be fruitful: (a) expand the case to include the partner, (b) psychoeducation regarding healthy masturbation and pornography use, and (c) training in communication with assertiveness. In the abstract, there is, of course, no dividing line between reasonable and unreasonable demands of a partner, and there will no doubt be debate regarding whether a given restriction is a reasonable demand to make of one's partner or whether mental health professionals should have any say in what a reasonable demand is. Typically, sex-positive clinicians quickly identify the clients' spouses' demands as overly or unnecessarily restrictive. On the other hand, the clients are aware of and have (usually explicitly) agreed to those restrictions. Thus, the clinician can be put in the role of taking a side: Is the therapeutic goal to address one partner's restrictions or the other partner's failure to maintain the agreed-upon behaviors? In practice, it can be helpful first to educate the couple regarding the healthy nature of masturbation (etc.), to help the couple to explore or re-negotiate their boundaries, and to help the husband to confront and discuss rather than evade the problem.

Conventional diagnostic systems. Clients presenting with this problem rarely meet DSM-IV-TR criteria for any sexual disorder or impulse-control disorder. Rather, V61.10 *Partner Relational Problem* frequently applies. Clients in this situation also express high levels of sexual guilt. (Indeed, reasonable discussion can be had regarding to what extent the Designated Patient phenomenon is redundant with the Sexual Guilt phenomenon.) Most men in contemporary society would quickly and easily reject the suggestion that (for example) all masturbation represents a problem, never mind a problem that merits clinical intervention; however, the men who accept the demand that they live highly restricted sexual lives and who enter into long-term relationships with women who hold such beliefs are often themselves sexually inhibited or

religious. Other situations can also be imagined, such as relationships wherein one partner is generally passive. In the ICD-10, F68.8 *Relational Disorder NOS* may apply.

Better Accounted For As a Symptom of Another Condition

There exist several, essentially non-sexual diagnoses that nonetheless include hypersexuality as one of its symptoms or sequelae. These include certain personality disorders, hypomania, disinhibiting brain injuries or neurological diseases, and developmental delay. There have also been reports in the literature of hypersexual behaviors following the administration of certain psychotropic medications. The existence of these phenomena is a reminder of the need for broad history-taking. The most common syndrome for which hypersexuality has presented to our clinic as a single aspect is personality disorder, especially *Borderline Personality Disorder.*

> *CASE 32 is a 39-year-old, openly gay man reporting a history of depression, multiple suicide attempts, and embezzlement from employers to support what the client called his addictions to sex and to shopping. The client reported that, since age 14, he engaged in anonymous sexual encounters with men, generally twice weekly to daily, in parks, public washrooms, adult movie theatres, and bathhouses. When asked to estimate his number of sexual partners, he said, "I have no clue. I'm horrified to think about it. To think about it would emotionally scar me." He subsequently estimated 500–900 sexual partners. Since acquiring a computer 14 years ago, he has spent 3–8 hrs/day online (including while at work) viewing male-male pornography and chatting to arrange sexual encounters. The client similarly reported purchasing, selling, and repurchasing thousands of compact discs, spending entire days perusing music online or at local music stores, and shopping after satisfying sexual encounters as a reward to himself.*

The client admitted embezzling money from his employers to pay his entrance fees into bathhouses, purchase pornographic movies, or hire a taxi ride to meet someone for sex. His embezzlement has led to his termination from three separate employers. He is on a leave of absence from his current employment, which his employer suggested as a result of his most recent suicide attempt.

The client has been in a long-term, cohabitating relationship with his partner for more than 10 years. They have an ostensibly monogamous relationship, but the client reported his partner to be unaware of the extramarital encounters, and he described their relationship as "rocky and stressed." They have had no sexual contact with each other for the past five months, the client reporting he feels too guilty about his affairs. The client reported he has no close friends, "A lot of people know me, but I'm a bit of a hermit."

He reported he has "blocked out" most of his memories of his childhood, but that he believes he was "gang raped" by four classmates while in high school. He reported that the details of the incident were "fuzzy" and that it was never reported to authorities. He indicated struggling in school classes when his "relationship with the teacher did not suit [him]." He explained that he was once expected to earn good grades in a particular class, and as a result, he purposefully failed the course. He attended some college, but discontinued his education because he wanted to "party and socialize."

The client's first suicide attempt was in his teens, secondary to distress about his sexual orientation and being the victim of bullying. His most recent suicide attempt was by overdose of pain-killers, secondary to distress over his sexual addiction. He has participated in psychotherapy previously, terminating treatment after 3–4 sessions,

saying "I didn't want to talk about the sex stuff." Currently, he sleeps 16–18 hours per day and binge eats (fasting for 3–4 days, then eating large quantities in one sitting). He denied global anhedonia, reporting that he continues to enjoy listening to music, watching television, and reading books.

Consistent with the literature on *Borderline Personality Disorder,* clients attending our clinic with this profile have very commonly been women and gay men. *Anti-Social Personality Disorder* can also include hypersexuality as a symptom (often termed "promiscuity" in that context), which appears to occur predominantly in heterosexual men. Although our clinic receives many referrals from men with *Anti-Social Personality Disorder* including hypersexuality, such men do not typically report distress and seek assistance to stop the behavior.

Referrals of this type sometimes report extremely high masturbation rates, resembling Avoidant Masturbation, or very many instances of adultery, resembling Chronic Adultery. (We have not observed any remarkable frequency of paraphilic interests or paraphilic behavior, however.) The primary distinction between personality disorders and the other types of hypersexuality referral is in the presence of the other symptoms of the personality disorder, rather than in any obvious difference in the sexual behaviors themselves.

Interestingly, the number of referrals to our clinic fitting this type have been comparatively few (<5%), whereas there can appear to be many in the public view. It would be interesting to speculate to what extent the preference of the commercial media to depict emotional drama and sexual situations of celebrities exaggerates their apparent occurrence.

Many, or most, of the other disorders that include hypersexuality with any sizeable frequency are disorders associated with disinhibition. That is, in such cases, the extremely frequent sexual behavior is one among multiple extremely frequent behaviors. We have not yet

encountered a referral for whom a neurological or other disinhibiting disorder was associated with Chronic Adultery, but have encountered several that showed extremely frequent masturbation or frankly bizarre behaviors that could resemble paraphilias. In the absence of information about a referral's premorbid sexuality, however, this can remain unknown.

Suggested interventions. The personality and other disorders that have hypersexuality as a symptom are included in this one type because, thus far, they appear to be best addressed in the same way: according to the overarching disorder rather than according to the hypersexual symptom(s). It is beyond the scope of this article to review the treatment literatures for each of these; however, in many referrals to our clinic—especially from clinics specialized for people with other disorders—there has seemed to be an avoidance among professionals to integrate the clients' sexual behaviors into his or her clinical profile. That is, out-of-control sex is sometimes automatically viewed as something distinct from other out-of-control behaviors and in need of special attention. In practice, it has been useful to establish a consultative role with clinicians already treating the overarching disorder.

Conventional diagnostic systems. Many referrals of this type show multiple symptoms of a DSM-IV-TR personality disorder, and very often meet criteria for a full diagnosis of 301.83 *Borderline Personality Disorder* or 301.9 *Personality Disorder Not Otherwise Specified* (i.e., 301.9 *Mixed Personality*). Although such clients provide their sexual concerns as their primary complaint, those concerns are one among multiple maladaptive behaviors. At the time of this writing, the structure of the personality disorders in DSM-5 was still undergoing significant revision, obviating discussion about whether and how this type of referral would be labeled in that system. In the ICD-10 system, the most relevant designation is typically F60.3 *Emotionally Unstable Personality Disorder,* which includes both an *Impulsive* and a *Borderline* subtype.

Discussion

As noted already, there are multiple features which clinicians or researchers may deem the essential ones and by which one may delineate types of hypersexuality referral. The present treatment-oriented approach represents only one. Other authors have proposed other typologies, and still more will undoubtedly emerge, based on other combinations of features, until there exist sufficient etiological data to support a formal taxonomy (i.e., a typology based on etiology). Until that time, treatment orientations may be the most useful approach for clinical purposes.

What would happen if a researcher examined a heterogeneous sample of hypersexuals (i.e., consisting of multiple types rather than one type)? The data would show a broad range of low-grade associations. That is, if one type show extremely high amounts of one feature, and another type has atypically low amounts of another characteristic, then we would obtain a single heterogeneous sample that is only a bit elevated on the one feature, and a bit depressed on the other. Taken further: A heterogeneous sample composed of six types would show a very wide range of atypical characteristics, each with a small effect size (making replications very difficult, especially if the samples are small). Remarkably, this appears to describe a sizeable portion of the published literature on hypersexuality: A researcher could hypothesize a deficit or excess in any of many characteristics, and (lacking an explicit method of isolating comparatively homogeneous subgroups) obtain a heterogeneous sample that reveals the hypothesized feature, and declare the feature to be relevant to everyone rather than to a subset only.

Although authors vociferously debate the distinctions between “compulsion” and “impulsion” or “addiction” and “dependence,” (etc.), the clients themselves (and most of their primary care providers) use those terms only as rough synonyms. That is, despite the technical terminological distinctions, the non-expert will apply the term “sexual addiction” (etc.) to denote

any phenomenon that has these two features: (a) It pertains to sex, and (b) it feels, or reportedly feels, outside the person's control.

The categories of this typology are not mutually exclusive. That is, having features of one type does not obviate having features of the other types; nor does the absence of one (or more) features of one type necessarily indicate that that type is irrelevant. That is, clients who appear to fit more than one of these types may benefit from the interventions suggested by each of those types.

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Footnotes

[1]*Hebephilia* refers to the sexual interest in children in early pubescence (Glueck, 1955), typically ages 11–14.

[2]There does not exist any universal term to describe persons with this combination of physical traits. Many such persons describe themselves as *she-males,* express the desire to retain their penis while living socially female lives, and pride themselves on their mixed status; however, there also exist male-to-female transsexuals who abhor their male genitalia and express offense at the term she-male.