## ORIGINAL RESEARCH

# Hypersexuality and High Sexual Desire: Exploring the Structure of Problematic Sexuality

Joana Carvalho, PhD,* Aleksandar Štulhofer, PhD,† Armando L. Vieira, PhD,‡ and Tanja Jurin, PhD§

*Center for Psychology, Faculty of Psychology and Educational Sciences, University of Porto, Porto, Portugal; †Department of Sociology, Faculty of Humanities and Social Sciences, University of Zagreb, Zagreb, Croatia; ‡DEGEI/GOVCOPP, University of Aveiro, Aveiro, Portugal; §Department of Psychology, Faculty of Humanities and Social Sciences, University of Zagreb, Zagreb, Croatia

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**ABSTRACT**

***Introduction.*** The concept of hypersexuality has been accompanied by fierce debates and conflicting conclusions about its nature. One of the central questions under the discussion is a potential overlap between hypersexuality and high sexual desire. With the relevant research in its early phase, the structure of hypersexuality remains largely unknown.

***Aim.*** The aim of the present study was to systematically explore the overlap between problematic sexuality and high sexual desire.

***Methods.*** A community online survey was carried out in Croatia in 2014. The data were first cluster analyzed (by gender) based on sexual desire, sexual activity, perceived lack of control over one's sexuality, and negative behavioral consequences. Participants in the meaningful clusters were then compared for psychosocial characteristics. To complement cluster analysis (CA), multigroup confirmatory factor analysis (CFA) of the same four constructs was carried out.

***Main Outcome Measures.*** Indicators representing the proposed structure of hypersexuality were included: sexual desire, frequency of sexual activity, lack of control over one's sexuality, and negative behavioral outcomes. Psychosocial characteristics such as religiosity, attitudes toward pornography, and general psychopathology were also evaluated.

***Results.*** CA pointed to the existence of two meaningful clusters, one representing problematic sexuality, that is, lack of control over one's sexuality and negative outcomes (control/consequences cluster), and the other reflecting high sexual desire and frequent sexual activity (desire/activity cluster). Compared with the desire/activity cluster, individuals from the control/consequences cluster reported more psychopathology and were characterized by more traditional attitudes. Complementing the CA findings, CFA pointed to two distinct latent dimensions—problematic sexuality and high sexual desire/activity.

***Conclusion.*** Our study supports the distinctiveness of hypersexuality and high sexual desire/activity, suggesting that problematic sexuality might be more associated with the perceived lack of personal control over sexuality and moralistic attitudes than with high levels of sexual desire and activity. **Carvalho J, Štulhofer A, Vieira AL, and Jurin T. Hypersexuality and high sexual desire: Exploring the structure of problematic sexuality. J Sex Med 2015;12:1356–1367.**

***Key Words.*** Hypersexuality; Sexual Desire; Dysregulated Sexuality; Problematic Sexuality

 

## Introduction

Recurrent and intrusive sexual thoughts and fantasies, excessive sexual behaviors, and the inability to control one's sexuality despite negative consequences have been conceptualized under the heading of hypersexuality. This symptomatic cluster though is not new; excesses of sexual behaviors resulting in negative personal and/or social outcomes have been described over the years [1,2]. However, only recently, and due to the suggested impairing nature of hypersexuality associated phenomena, hypersexual disorder was proposed for inclusion in Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) but rejected at the final stage [3]. During this process, the efforts to conceptualize hypersexuality as a formal disorder generated heated debates and drew strong criticism. For example, some challenged the notion that hypersexual disorder is a distinct entity, pointing to problems in distinguishing hypersexuality from high sexual desire [4], which violate the uniqueness and distinctiveness of the new concept required for inclusion in the new DSM [5]. In addition, a number of critics warned about the stigmatizing potential of the new diagnosis [6]. Pathologizing "too much sex" may produce negative feelings—including self-blaming shame and guilt—prompting some individuals characterized with above-average sexual interest to blame their sexuality for any adverse life events. Noting strong comorbidity between dysregulated or problematic sexual behavior and mental disorders, some clinicians have further suggested that hypersexuality may be a consequence (or a symptom) of another clinical disorder rather than a sexual disorder *per se* [7]. Several etiological pathways were assigned to hypersexual disorder (from obsessive-compulsive spectrum to impulse-control and addiction-like disorder). In spite of these so many views, this putative disorder was ultimately conceptualized as a sexual desire disorder with an impulsivity component [8]. A typical case of hypersexual disorder would be expected to display three major symptomatic clusters: unsuccessful attempts to control one's sexuality, using sex as primary coping mechanism, and experiencing negative consequences of one's sexual behavior; nevertheless, more profiles may exist as systematic research on this topic has recently just began [9,10].

Notwithstanding the recent rejection of hypersexual disorder, the analytical and clinical utility of a broader concept of hypersexuality remains unclear [11]. For these reasons, this article focuses on hypersexuality as a set of clinically relevant characteristics and symptoms. In assessing its distinctiveness from high sexual desire, which is the focus of this article, we refrain from any speculation regarding the existence of an underlying disorder.

In an attempt to understand the nature of the hypersexuality phenomenon, Walters et al. [12] conducted a study aimed at finding whether hypersexual behavior could be better defined as dimensional or categorical. Findings pointed to the dimensionality of the construct suggesting that hypersexuality is organized along a continuum, ranging from low sex/fantasies frequency to high sex/fantasies frequency. Clinically relevant cases would fall at the upper end of this continuum, and would be characterized by high levels of sexual desire and/or frequent sexual activity that eventually fall out subjects' control. It is worth noting, however, that in the first sample used in the study (men and women from general population) proxy indicators of hypersexuality were confined to behavioral markers (i.e., excessive sexual activity). Only in the second sample (male sex offenders) the indicators of hypersexuality were modeled after a closer representation of hypersexuality by including both behavioral (inability to stop sex when want) *and* cognitive (inability to stop thinking about sex) proxies. Considering that sexual desire implies a cognitive dimension, which was only measured in the sample of male sex offenders, it follows that evidence on the dimensionality of hypersexuality and the positioning of hypersexuality at the upper end of the sexual desire continuum may be highly group specific.

Winters et al. [5] explored the structure of hypersexuality by assessing its overlap with high sexual desire. Their findings pointing to a strong overlap between sexual desire and problematic sexual behavior, the authors concluded that hypersexuality diagnosis lacks empirical support. Although the authors recognized that negative outcomes and personal distress may accompany hypersexuality/high sexual desire phenomenon, they rejected the notion that the distress *per se* is sufficient for the recognition of hypersexual disorder. Interestingly, hypoactive sexual desire disorder (HSDD) has been long accepted as a clinical entity based on clinically significant distress caused by low or diminished sexual desire. Nonetheless, it is not without contestation that HSDD has been regarded as a formal disorder [13–15]. In an earlier study, Winters and his team provided evidence that sexual desire, but not sexual compulsivity, negatively impacted self-reported capability to regulate