REVIEWS

Which Techniques Are Used in Psychotherapeutic Interventions for Nonparaphilic Hypersexual Behavior?

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ABSTRACT

Introduction. Attempts to draw a distinction between excessive and so-called normal sexual behavior are discussed controversially. Although no consensus has been reached so far on how to label the phenomenon of clinical relevant excessive sexual behavior, Kafka proposed the term hypersexual disorder. There are only a few empirical studies on the effectiveness of treatment. In the recent systematic review by Hook and colleagues, the total number of subject-related studies amounts to only 14 studies. However, it might be difficult for mental health professionals to fully comprehend the intervention techniques used in the different studies.

Aim. The present article aims at reviewing the psychotherapeutic interventions for nonparaphilic hypersexual behavior use.

Method. Each study mentioned in the recent review by Hook et al. was analyzed with regard to the psychotherapeutic interventions that had been applied. Only studies with positive treatment outcomes were considered. From among those studies, only the interventions which seemed to be sufficiently detailed and which are related to the obvious therapeutic results in the treatment of hypersexual symptoms were chosen. Furthermore, the interventions were assigned to the proposed diagnostic criteria of the hypersexual disorder.

Results. The hypothesized mechanisms how certain treatment techniques could change and influence hypersexual symptoms were mostly described in an unsatisfactory way. Interventions were targeted on impairment in social, occupational, or other important areas of functioning, negative mood states, stressful life events, and lack of behavioral control. No specific interventions were included for the risk for physical or emotional harm to self or others.

Conclusion. Future treatment approaches should explicitly formulate the etiological mechanism and contain interventions for the neglected areas. In addition, a more flexible approach in the treatment of different subgroups with hypersexual behavior might be promising. **von Franqué F, Klein V, and Briken P. Which techniques are used in psychotherapeutic interventions for nonparaphilic hypersexual behavior? Sex Med Rev 2015;3:3–10.**

Key Words. Hypersexual Disorder; Hypersexuality; Sexual Addiction; Sexual Compulsivity; Sexual Impulsivity; Treatment

Introduction

Deviations in quantity and quality from the so-called normal sexual behavior have been described since the beginnings of sex research [1,2]. The qualitative deviations in terms of paraphilic disorders or disorders of sexual preferences were included in the International Classification of Diseases [3] and the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; [4]) in a relatively consistent manner. However, there has been an ongoing debate regarding the definition of excessive nonparaphilic sexual behavior and its appropriate labeling: Carnes [5] coined the term *sexual addiction* to describe a deregulated sexual desire that

Table 1 Proposed diagnostic criteria for hypersexual disorder

A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors in association with three or more of the following five criteria:
   A1. Time consumed by sexual fantasies, urges, or behaviors repetitively interferes with other important (nonsexual) goals, activities, and obligations.
   A2. Repetitively engaging in sexual fantasies, urges, or behaviors in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
   A3. Repetitively engaging in sexual fantasies, urges, or behaviors in response to stressful life events.
   A4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, or behaviors.
   A5. Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.
B. There is clinically significant personal distress or impairment in social, occupational, or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, or behaviors.
C. These sexual fantasies, urges, or behaviors are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication).

Specify if:
Masturbation, pornography, sexual behavior with consenting adults, cybersex, telephone sex, strip clubs, other

reduces the motivation or capacity to control sexual behavior despite its harmful consequences. In contrast, Coleman [6,7] conceptualized excessive sexual behavioral patterns as *sexual compulsivity*. Sexual compulsive behavior is characterized by intrusive and repetitive fantasies, thoughts, and urges that cause anxiety and distress and are followed by sexually obsessive behaviors as a temporary regulation. Nevertheless, other authors simply defined sexual compulsivity as a lack of control over sexual behavior [8]. Barth and Kinder [9] criticized the practice of labeling the phenomenon as an addiction or a compulsive disorder. Instead, an atypical impulse control disorder was postulated in order to qualify the inability to control strong sexual wishes or the preoccupation with sex. Therefore, the term sexual impulsivity was suggested. However, the phrase *strong sexual wishes* is suggestive of an increased sexual drive that is not a defining feature of the atypical impulse control disorders. Bancroft and Vukadinovic [10] criticized the premature allocation of the phenomenon to existing psychopathological categories, arguing that there might be different etiological mechanisms for the same kind of excessive sexual behavior. As a consequence, the authors preferred "the general descriptive term out of control (. . .) sexual behavior" [10, p. 223]. Notwithstanding our regards for these authors and their analysis of the role of emotions and affects play in with regard to the said phenomenon, we respectfully disagree with the authors concerning the proposition that the phrase *out of control* is a descriptive one. Like the term *sexual impulsivity*, it suggests a control problem. In order not to speculatively associate the phenomenon with existing psychopathological frameworks, Kafka [11] introduced the concept of the paraphilia-related disorder, arguing that "such behaviors (. . .) share many of the same characteristics as the family of paraphilic disorders" [12, p. 477]. Kafka defined the paraphilia-related disorders as the increased expression of not socially deviant sexual fantasies, urges, and behavior that are not thought to be socially deviant [13].

The conceptualizations mentioned above have a lot in common with each other in a descriptive and empirically validated manner [13]. As a part of the revision process of the DSM-5, the term *hypersexual disorder* was proposed [13]. The conceptualization avoided using phrases that link the disorder to an etiological model or theory and focused on features and characteristics instead (see Table 1). For the purpose of this article, the term *hypersexual disorder* will be used following Kafka's definition. We use the terms hypersexual behavior or hypersexual symptoms to describe single characteristics or criteria of hypersexual disorder.

Although there has been a controversial discussion concerning the most appropriate label and the possible etiological models in the scientific literature [13–16], there are only a few empirical studies with an emphasis on hypersexual disorder and its treatment: In their systematic review, Hook et al. [17] identified 14 publications that analyzed the influence of different treatment approaches on nonparaphilic hypersexual behavior. From among these studies, six studies focused on the effects of pharmacological therapy: These publications concentrated on the effects of drug treatment with noradrenergic serotonergic reuptake inhibitors [18], selective serotonin reuptake inhibitors [19–21], opiate agonists [22], and psychostimulant augmentation during the treatment with selective serotonin reuptake inhibitors [23]. In one of these articles [19], participants did not begin a new course of psychotherapy while taking medication. However, possible histories of psychological