



# Revista de Psiquiatría y Salud Mental

[www.elsevier.es/saludmental](http://www.elsevier.es/saludmental)



## SCIENTIFIC LETTER

### Primary hypersexuality: Nosological status, pathogenesis, and treatment<sup>☆</sup>

#### Hipersexualidad primaria: estatus nosológico, etiopatogenia y tratamiento

Sir,

Hypersexuality is a psychopathological alteration frequently associated with various psychiatric and neurological symptoms.<sup>1,2</sup> It sometimes becomes the main symptom that the patient presents, consequently acquiring the level of mental disorder.

We present the case of a 16-year-old female adolescent referred to the Child and Adolescent Mental Health Centre in Mataró for assessment for sexual promiscuity.

The patient reported fantasies and constant hypersexual activity since she was 15, with compulsive masturbation (3–4/day) and multiple sexual encounters (1–2/week) using prophylactics. Throughout this period, there was intermittent school absenteeism (she went to the park to run and voluntarily bumped into men). Likewise, she was incapable of maintaining a stable romantic relationship, with infidelities when she had a partner. She reported exacerbation of the hypersexual behaviour in the context of stress, indicating that there was a transitory relief from discomfort when an organism was reached. She stated that her self-esteem increased by feeling desired by many men. For several months, there has been a sensation of lack of control over these impulses, which motivated the application for treatment.

Her birth and puerperium were without any incidences; standard development through the growth landmarks, with no delay in learning. Premature menarche (9 years old). She was described from infancy as a child who was “insecure and with low self-esteem”. She indicated that, when she was 12, she suffered a sexual aggression with a penetration attempt from an unknown adult, which she did not tell anyone about because she felt ashamed. She reported that, after that, she exhibited symptomatology compatible with compatible PTSD until 14 years of age (nightmares, fear of the dark, flashbacks, situational avoidance, separation anxiety),

minimising the symptoms in the family environment. At the social level, she has maintained a few friendships since early adolescence. Her first consented sexual relationship at 15 years. No use of toxic substances. Good school performance, with a discrete academic decline during the last course (a failing mark). Appropriate family adjustment, with no discord among family members or psychiatric antecedents of interest.

During the interview, she was found to be aware and alert, with a cordial and collaborative attitude. Hygiene was preserved. Fluid and spontaneous speech, with noticeable sexual ruminations of an ego-syntonic nature, nonparaphilic and heterosexual, with secondary hypoprosexia (difficulty in paying attention to class explanations). Likewise, she reported fear of rejection in the context of emotional openness. She denied psychotic symptomatology (for example, delusions of grandeur or prejudice). At the affective level, she showed moderate prolonged emotional lability, with no seasonal or circadian pattern. No suicidal ideation, desperation or anhedonia. She showed excessive libido, with dysphoria secondary to loss of behavioural control. She reported occasional nightmares related to the aggressor, without any other associated PTSD symptoms (such as separation anxiety, place avoidance, intrusive images, etc.). No alterations in eating behaviour. Consciousness of illness.

During the 11 months that she has been under outpatient treatment, a slight decrease in hypersexual activity has been observed; she has channelled this psychopathology in a less maladaptive manner, through a stable couple relationship. With respect to this point, the patient has maintained a romantic bond for 9 months, with no infidelity after the first third of the relationship. They have sexual relations 3 times a day and she masturbates once a day in addition. With respect to the sexual ruminations, the improvement has been more pronounced; the secondary hypoprosexia has decreased, which has led to improved school performance (no failing marks). Her mood lability has also lessened in intensity and duration.

Regarding the therapeutic measures adopted throughout the therapeutic process, at first the focus was on reducing her hypersexual behaviour by “stimulus control” (going out with female friends only) and “differential reinforcement of low rates” (limiting compulsive masturbation). With these techniques, only a slight reduction of this psychopathology was achieved, given that the patient did not always comply with the prescribed objectives. After 3 weeks of psychological follow-up, drug treatment with

<sup>☆</sup> Please cite this article as: Frías Ibáñez A, Vázquez Costa M. Hipersexualidad primaria: estatus nosológico, etiopatogenia y tratamiento. Rev Psiquiatr Salud Ment (Barc.). 2012;5:205–7.

sertraline 50 1-0-0 was initiated, considering day hospital admission if the degree of psychosocial dysfunction persisted. Following a month of concomitant treatment with psychotropic medication, the patient reported improvement in her mood, as well as a partial reduction in the excess sexual desire. In respect to the sexual ruminations, she was given instructions in distracting techniques (reading), having to be trained later in "being fully aware" because she used the first techniques compulsively (reading 6 books at a time). Through mindfulness techniques, the patient stated that she was optimising her capacity for behavioural self-regulation in risk situations (such as feeling sexual desire upon seeing a male stranger). Apart from the hypersexuality, a more introspective intervention was performed later, with exposure to feelings of self-devaluation in the therapeutic environment without experiencing interpersonal rejection.

Hypersexuality is a psychopathological alteration frequently associated with various psychiatric and neurological symptoms.<sup>1,2</sup> It sometimes becomes the main symptom that the patient presents, constituting a clinical entity by itself. There is notable disagreement about the conceptualisation of primary hypersexuality.<sup>3</sup> It has been formulated as a dysfunction of sexual desire,<sup>4</sup> a pathology on the obsessive spectrum,<sup>5</sup> a behavioural addiction<sup>6</sup> and an impulse control disorder.<sup>7</sup> This lack of epistemological consensus has led to the fact that its nosological status has been irrelevant from the time it was initially included among the "unspecified psychosexual disorders" of the DSM-III (1980). This was a category that gathered together the subjects whose "*distress* about a pattern of repeated conquests that exist as mere things to be used". Following in this same line, within the nosological framework in force, the clinical practitioner who is familiar the DSM-IV-TR should continue using the residual label "unspecified sexual disorder". On the other hand, the CIE-10 mentions this construct explicitly ("excessive sexual drive"), but does not offer an operative definition of it. In short, the current reference guides lack a diagnostic category that collects the clinical characteristics of this disorder.

As for its aetiopathogenesis, the majority of the studies are transversal or retrospective, without a comparative control group; consequently, the resulting findings have to be viewed with precaution. There is a relative consensus about the greater prevalence of primary hypersexuality in males (5:1), with findings of numerous antecedents of sexual abuse in the subgroup of female patients.<sup>8</sup> Likewise, highly frequent avoidant attachments, self-criticism and feelings of shame have been demonstrated.<sup>9</sup> This suggests that promiscuity could be an alternative form of satisfying filiation and interpersonal validation needs.<sup>10</sup> In the same way, it is postulated that sexual drive is exacerbated in the face of frequently comorbid affective symptoms,<sup>11</sup> with the hypersexuality acting as an emotional self-regulation mechanism.<sup>7</sup> With respect to the neuroendocrine hypotheses, there is indirect evidence that would implicate monoamine involvement, principally through libido increase with dopaminergic agents<sup>4</sup> and the "inhibiting" effect of serotonergic substances.<sup>12</sup> In the environment of functional neuroanatomy, there are preliminary tests that would suggest frontal lobe hypoactivity, above all in studies that have found an executive function deficit.<sup>13</sup>

With respect to treatment, there are hardly any randomised trials with control groups that make it possible to obtain conclusive results. At the psychopharmacological level, the majority of clinical research indicates a reduction of hypersexuality through SSRIs.<sup>8,12</sup> On the other hand, a high response rate was obtained with citalopram administration in the only experimental study carried out, although this benefit was similar to that shown by placebo.<sup>14</sup> Regarding psychotherapy, we have only found a randomised controlled trial, in which the subjects that attended group therapy for 5 months reduced their sexual promiscuity significantly.<sup>15</sup> Lastly, it is advisable to indicate that our patient was the first hypersexual patient who used mindfulness techniques, producing a therapeutic gain as well.

Summarising, primary hypersexuality is a construct included in a residual form in the current psychiatric taxonomy. The absence of an operative definition makes it impossible to generalise the findings obtained in the samples studies. At the nosological level, including it among the sexual dysfunctions of desire is suggestive, considering the presence of "hypoactive sexual desire" in that category. In the aetiopathogenic realm, more longitudinal studies have to be carried out to determine the multifactorial nature of this disorder; that is to say, to evaluate whether it also represents a mechanism of emotional self-regulation, filiation and/or a post-traumatic reaction (this last response being seen in hypersexual females). Furthermore, promoting functional neuroimaging studies is a priority so as to grasp its biological correlates. With respect to treatment, further clinical trials with control groups are needed to calibrate the true therapeutic reach of cognitive-behavioural techniques (mindfulness) and antidepressants (SSRIs).

## References

1. Krueger RB, Kaplan MS. Disorders of sexual impulse control in neuropsychiatric conditions. *Semin Clin Neuropsychiatry*. 2000;5:266-74.
2. Frías A, Malea A, Dorado M, Mongay H. Síndrome orbitofrontal tras una operación por un aneurisma cerebral. A propósito de un caso. *Actas Españolas de Psiquiatría*. 2008;36:362-5.
3. Kaplan MS, Krueger RB. Diagnosis, assessment, and treatment of hypersexuality. *J Sex Res*. 2010;47:181-98.
4. Kafka MP. Hypersexual disorder: a proposed diagnosis for DSM-V. *Arch Sex Behav*. 2010;39:377-400.
5. Coleman E. The obsessive-compulsive model for describing compulsive sexual behavior. *Am J Prev Psychiatry Neurol*. 1990;2:9-14.
6. Goodman A. What's in a name? Terminology for designating a syndrome of driven sexual behavior. *Sex Addict Compulsiv*. 2001;8:191-213.
7. Bancroft J, Vukadinovic Z. Sexual addiction, sexual compulsivity, sexual impulsivity or what? Toward a theoretical model. *J Sex Res*. 2004;41:225-34.
8. Black DW, Kehrberg LLD, Flumerfelt DL, Schlosser SS. Characteristics of 36 subjects reporting compulsive sexual behavior. *Am J Psychiatry*. 1997;154:243-9.
9. Guigliamo J. Out of control sexual behavior: a qualitative investigation. *Sex Addict Compulsiv*. 2006;13:361-75.
10. Reid RC, Harper JM, Anderson EH. Coping strategies used by hypersexual patients to defend against the painful effects of shame. *Clin Psychol Psychother*. 2009;16:125-38.

11. Raymond NC, Coleman E, Miner MH. Psychiatric comorbidity and compulsive/impulsive traits in compulsive sexual behavior. *Compr Psychiatry*. 2003;44:370–80.
12. Kafka MP. Sertraline pharmacotherapy for paraphilias and paraphilias-related disorders: an open trial. *Ann Clin Psychiatry*. 1994;6:189–95.
13. Reid RC, Karim R, McCrory E, Carpenter BN. Self-reported differences in measures of executive function and hypersexual behavior in a patient and community sample of men. *Int J Neuropsychiatr*. 2010;120:120–7.
14. Wainberg ML, Muench F, Morgenstein J, Hollander E, Irwin TW, Parsons JT, et al. Citalopram vs placebo in the treatment of compulsive sexual behaviors in gay and bisexual men. *J Clin Psychiatry*. 2006;67:1968–73.
15. Quadland MC. Compulsive sexual behavior: definition of a problem and an approach to treatment. *J Sex Marital Ther*. 1985;11:121–32.

Álvaro Frías Ibáñez\*, María Vázquez Costa

*Centro de Salud Mental Infanto-Juvenil, Hospital de Mataró, Mataró, Barcelona, Spain*

\*Corresponding author.

*E-mail address:* [alvarofriasibanez@gmail.com](mailto:alvarofriasibanez@gmail.com)  
(Á. Frías Ibáñez).