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Comment on Moser's “Hypersexual Disorder: Searching for Clarity”

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Comment on Moser’s “Hypersexual Disorder: Searching for Clarity”

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Dr. Moser is an outlier in this special issue, as he obviously opposes the notion of Hypersexual Disorder (HD). Indeed, he has opposed considering as disordered most forms of atypical sexual behavior, including paraphilias, instead encouraging a viewpoint that sexual expression in itself is natural, regardless of its form and the degree of difference from what might be considered typical or within normal limits. Thus, his present paper is consistent with his previous statements, and from an a priori perspective, might be a reasonable starting place for one to hold, as ultimately, whether or not something should be viewed as disordered is, to a great extent, a judgment call, involving attitudes and personal values. It is extremely helpful to have a critic challenge both the science of HD and the interpretation of data from studies of HD; those who see merit in having an HD diagnosis available to describe and aid in the understanding of persons who experience clinically significant distress and/or functional impairment related to their atypical sexual behavior can benefit. Such criticism obligates us to be honest with our data and can help guide research.

Unfortunately, although it adds a few particulars, this article has little new to offer beyond previous comments (e.g., Moser, 2011) to which many have responded (e.g., Kafka & Krueger, 2011). Although it claims to be a challenge of HD, it is actually more of a critique of a few statements from Kafka’s 2010 review. Even so, it can serve as a reminder that we have work to do, such as to better understand: (a) the impact of allowing clients to self-define “excessive”; (b) the role of potential risk factors, such as impulsivity or negative mood states; (c) comorbidity (see Carpenter, Reid, Garos, & Najavits, this issue); and (d) ways of militating against potential misuse of the diagnosis (such as in the courts).

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Moser selectively applies to HD an unrealistic threshold for considering an emerging disorder. Although there is no universally agreed-upon definition of what constitutes a mental disorder, DSM-IV-TR offers the conceptualization of “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas off uctioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss off reedom.” (e.g., DSM-IV-TR, 2000, p. xxxi). All of these are present among those who seek treatment for HD or related conditions (e.g., sexual addiction). These individuals clearly see their sexual behavior as the focal point of their difficulties, even if they often present with comorbid conditions, and Moser is unable to present a cogent case for how in most cases another condition can account for their distress or dysfunction. Indeed, he offers no data directly revealing that other conditions account for maladaptiveness and dysfunction found in HD. His argument that HD arises in most cases from underlying conditions and that it is these conditions which should be treated in order to reduce the symptoms of HD is similar to past treatment practices used for substance use disorders which posited that treatment should be focused on underlying conditions of depression, neurosis, or interpersonal conflict instead of addressing the substance use disorder directly. No one would argue that comorbid conditions should not be treated, but substance abuse treatment practices have evolved to focusing on the substance use disorder directly and targeting it with a variety of treatments. Likewise other “behavioral addictions” (gambling, compulsive overeating, dysfunctional internet use) have adopted therapies that focus directly on controlling the behaviors themselves, rather than focusing on underlying conditions. It is true that there is disagreement as to the best label for hypersexual behavior that results in distress or dysfunction, mostly arising from differences in the suspected (but not yet well-understood) etiology of such behavior. However, the literature reflects that most often researchers are talking about the same people, target behaviors, and consequences, and that unifying criteria (especially which sidestep problem-laden and unproven causal models, as the etiologically neutral label of HD does) would add to consistency of approach and comparability of results. In fact, such disagreement about labels and etiological models is often present in DSM diagnoses (e.g., Multiple Personality Disorder versus Dissociative Identity Disorder, or spectrum disorders versus separate diagnoses).

This same inflating of difficulties arises in some of Moser’s specifics as well. For example, his analysis of purported impulsivity within HD relies on absolutes not representative of most impulsivity. His “anecdotal” analysis argues that because impulsive tendencies do not trump all, impulsivity must not be present. In fact, populations with well-documented impulsivity (e.g., Antisocial Personality Disorder) can act deliberately, have a rationale, and
temporarily postpone behavior (e.g., not many would carry out a plan to rob a convenience store if a policeman were standing at the counter). Rather, the question is whether impulsive tendencies are more likely to present in those with HD than in those without HD, and whether such impulsivity is a salient variable to include within the HD criteria. We must recognize that we still don’t know much about the role of impulsivity (an important reason it was not included in the proposed DSM definition). For example, we do not yet know if the impulsivity self-reported by clients is actually manifest in their behavior, and if persons with HD are more impulsive generally or if impulsive tendencies are limited to sexual behavior.

Moser’s criticism seemingly objecting to defining HD as non-paraphilic is confusing. Although initially Kafka conceptualized HD as being non-paraphilic, the criteria were subsequently clearly written such that HD could apply to individuals regardless of whether their sexual behavior was non-paraphilic or paraphilic. Moser’s apparent preference for considering sexual behavior broadly as normal regardless of its nature and harmful consequences seems to be at the crux of his argument: If all sexual behavior is normal, then why select out HD as a diagnosis? The contrasting approach would be to utilize the diagnosis of HD to distinguish sexual interest and behavior defined by dyscontrol and significant negative life consequences. Many individual with HD do not qualify for a paraphilic diagnosis (e.g., Black, Kehrberg, Flumerfelt & Schlosser, 1997; Raymond, Coleman & Miner, 2003), but some do (Krueger, Kaplan & First, 2009). Further research needs to be done using accepted and published criteria for HD.

Many researchers may share Moser’s concern that “sexual addiction” and other HD-like conditions have prematurely “entered the popular lexicon” or resulted in premature claims about treatment. However, it is reasonable for people to seek help for troubling conditions, and psychological interventions apparently have something to offer. Identifying a condition (even if called a “diagnosis”) and attaching a literature about presentation, etiology, course, and sequela seems both reasonable and expected if we are to help. That the broader psychiatric community has yet to endorse this as an accepted diagnosis, even for further study, reflects the state of knowledge and attitudes of the psychiatric community and those responsible for final inclusion of diagnoses in psychiatric manuals. To maintain that there is a lack of support for HD is simply wrong; there has been and is a growing body of studies and literature, which have progressively expanded and continue to expand the database supporting this diagnosis.

Finally, in dismissing the reliability of the HD criteria because the field trial (Reid et al., 2012) used clients from clinics which specifically treat such clients, Moser failed to report that the trial also included clients from other settings. It is worth noting that this is exactly the design expected of DSM-5 field trials and that the reliability, sensitivity, and specificity, which Moser overlooks, were high. This is not to say that we ought not to extend our
knowledge regarding those who do and do not endorse criteria, but the results are promising, regardless of Moser’s unsupported dismissiveness.

In sum, a reading of Moser’s review requires a critical mind and a bit of act checking. He reminds us of areas where we need to expand our knowledge base, but his critique is inadequate to suggest that Hypersexual Disorder inherently fails to meet a threshold for a diagnosable condition. Indeed, it underscores the need for some agreement on criteria for this condition and the best practice way of defining it, which the current criteria for Hypersexual Disorder provide.

REFERENCES


