"Hypersexuality: Social Normativity Gone Awry or Genuine Medical Problem?"

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INTRODUCTION

Sexuality is a topic filled with contradiction: it is near-universal, yet deeply private. Sexuality is deeply varied in its manifestations, yet “normal” sexualities are perpetually reinforced by social pressures. Cultural norms and social pressures help shape the concepts of “normal” sexuality, while governments and institutions enforce these normative boundaries. When organizations of power become involved in the sexuality of individuals, sexual minorities can become vulnerable. Incidents of laws and norms harming certain sexual minorites, such as members of the queer community, can be seen to this day. The institution this paper will focus on is medicine; namely, how the power of discourse within the medical community leads to the pathologization of certain sexual behaviors and has lead to the conception of “hypersexuality disorder”. There is no singular defiition of the proposed “hypersexuality disorder” (a clinical inconsistency which will be discussed later), but it essentially focuses on an indivual having “too much” or “too frequent” sex, to the point where it becomes clinically significant. The purpose of this paper is to use the debate regarding the legitimacy of the proposed hypersexuality disorder to answer several questions. To what extent is the pathologization of “non-normative” sexual behavior a result of true unmanagability of sexaulity, or the result of morality driven attempts to control sexual behavior and define “acceptable” sexuality? Who has the authority to draw the boundary between pathological sexuality and healthy sexual variance?

While examining this topic, I hope to view hypersexuality through multiple frameworks: through the perspective of the medical community, through the lens of defining addiction, and from a feminist perspective. Firstly, this paper will utilise the insight of various clinicians, including works by Paul Joannides and Charles Moser, to examine how variations between clinicians and their sex-based personal values may impact their clinical practices and lead to problematic variability in the diagnosis of a proposed hypersexuality disorder. This paper will also address

homosexuality within the DSM as a case study of sexuality being pathologized and subsequently depathologized, to demonstrate the discursive power of the medical community. This paper will examine the feminist rhetoric of Janice Irvine to explore the concept of pathologizing sexual behavior as a means of controlling women's bodies and promoting self recrimination and shame amongst women. Connected to this idea of social pressures being diagnostically formative, Joannides and psychologist Xijuan Zhang are referenced in a discussion of prescribed sexual boundaries, and how these boundaries can lead to institutions wielding discursive power to reinforce and shape these boundaries. These boundaries have implications for sexual pathologization. The efforts undertaken in this paper are done with the intention of creating a multifaceted explanation of the conception of hypersexuality as a disorder, and to question the motivations and validity of this proposed disorder. The ultimate goal of this piece is to support the argument that the proposed hypersexuality disorder is too variable and the pathologization of sexual behavior far too influenced by social normativity to allow for hypersexuality disorder to stand alone as a true medical diagnosis.

CLINICAL VIEWPOINT: PROFESSIONAL, MORAL, AND SYMPTOM VARIATION

The diagnosis and treatment of a proposed "hypersexuality disorder" may be problematic from a clinical viewpoint due to the diversity of experiences and perspectives on sexual behavior stemming from the clinical community. Since hypersexuality is a proposed psychological disorder, it is important to consider the viewpoint of the clinicians who may treat individuals' sexual behaviors. The issue that arises when considering sexual behavior from a clinical perspective is the lack of a singular, unified clinical perspective. In an article for *Psychology Today,* clinician Paul Joannides discusses this challenge, illustrating how different clinicians in different sub disciplines may widely vary on which sexual behaviors are considered "problematic" or disordered: "Perceptions can also be affected by the training and specialty of the clinician and the types of

patients the clinician sees" (Joannides, 2011). A psychologist that works with sex offenders or within the field of forensic psychology may seek to diagnose sexual behaviors that break laws or interfere with the rights and safety of others. A psychologist who works in the realm of family counseling may rather be concerned with a lack of sex within a marriage or partnership.

Along with bias borne out of professional subdiscipline, Joannides and writer Janice Irvine examine the economic incentives at play within the pathologization of sexual behavior. Feminist writer Janice Irvine's work identifies a social force which may incentivise the creation of pathological sexuality: "clearly economic incentives are central to medical expansion. Treatment for sexual desire problems is a vast and lucrative venture" (Irvine, 1997). Treatment centers and Sex and Love Addicts anonymous meetings proved to be very profitable. In addition, the creation of the concept of "sex addiction" helped to validate the struggling early field of sexology in the 1980s (Irvine, 1997). While citing the work of Irvine, Joannides further illustrates this point by claiming that "some of the private treatment centers that specialize in sexual addiction hired public relations firms years ago that may have helped further this idea" (Joannides, 2011). "This idea" refers to the conception of hypersexual behavior as an addiction issue or disorder. There are both economic and professional pressures and variations that have to be considered when examining the history of the formulation of hypersexuality as an addiction or pathology.

Individual variation in the personal values systems of clinicians has been shown to vastly impact the pathologization of sexual behaviors. Joannides states: "clinicians with a more conservative orientation may tend to view sexual behaviors that occur outside of traditional or prescribed boundaries as being pathological" (Joannides, 2011). There is significant danger in basing diagnostics on "prescribed boundaries" due to the many influences that go into creating these "boundaries." In a sentiment similar to that of Joannides,Xijuan Zhang writes in this literature review of hypersexuality that "the pathologizing of hypersexuality may cause clinicians with

conservative or negative attitudes towards sex to impose a pathological label on normal sexual behaviour" (Zhang, 2012). Thus, normal behavior may fall into a "disordered" category simply by virtue of not corresponding with a diagnosing clinician's personal value system or falling within "prescribed boundaries". According to a piece written by Dr. Charles Moser: "the DSM, as it currently exists, promotes our society's values and projects them onto patients" (Moser, 2001). In this way, the DSM becomes an instrument of propagating social normativity and setting prescribed boundaries or limits based on societal attitudes. While Joannides focuses on the impact of individual clinician value systems and Moser addresses social value systems, both clinicians concur that value systems influence sexual diagnoses, and as such a diagnosis' entrance into the DSM could be socially impactful. This is problematic because neither social nor individual value systems are relevant to true medical concerns. If hypersexuality is to be included as a formal disorder, the variability discussed in this section would make it impossible for such a disorder to be diagnosed with the standard of consistency that is expected in a medical setting.

PRESCRIBED BOUNDARIES AND THE MEDICALIZATION OF SEXUAL IDENTITIES

The issue of using "prescribed boundaries" as a metric for determining disordered sexual behavior has the potential to subjugate minority groups, with the treatment of homosexuality in the medical field being a cardinal example. As referenced earlier by Joannides, sexual prescriptions are essentially guidelines for "acceptable" sexual behavior based on social normativity, which is a consensus within a society on what is normal and acceptable, and what is not. In Western cultures, particularly the United States, norms have historically been based on the Christian faith and emphasize heterosexual intercourse within the confines of marriage. As psychologist Jack Drescher observes, "for much of Western history, official pronouncements on the meanings of same-sex behaviors were primarily the province of religions, many of which deemed homosexuality to be morally 'bad'" (Drescher, 2015). In what Drescher refers to as "organized medicine's official

participation in the social stigmatization of homosexuality" homosexuality was considered a disorder by the Diagnostics and Statistical Manual (DSM) until 1973 (Drescher, 2015). Within the temporal context, societal attitudes towards homsexuality were negative and rooted in religiousity. The reaction to this social attitude from the medical community was to turn an identity into a disorder. The present venture to pathologize "hypersexuality" should be reviewed through the lens of this example.

As demonstrated, cultural norms and religiosity can permeate the medical community and lead to identities being misnomered as disorders. Subsequently, reversing institutional pathologization can enable positive social change. In the case of homosexuality, cultural normativity permeated the medical community which reciprocated and reinforced these norms by claiming that this identity was disordered. Later on, the recindence of pathologization by the DSM had a positive effect on the cultural treatment of homosexuality. As Moser states: "it was when homosexuality was removed from the DSM that the civil rights of gay people were advanced" (Moser, 2001). Simlarly, Drescher reflects on how the 1973 DSM decision meant that "those who accepted scientific authority on such matters gradually came to accept the normalizing view" (Drescher, 2015). Drescher addresses how the institution of medicine has the authoritative influence to create this "normalizing view" of sexual behaior, which enables the advancement of gay rights as discussed by Moser. Homosexuality is not only an example of mistakes made by the medical community, but reveals how identity politics can hugely impact and regulate sexual behaviors. This concept is best explored in a feminist perspective.

PATHOLOGIZATION OF SEXUALITY: A FEMINIST PERSPECTIVE

Feminist writer Janice Irvine discusses how the pathologization of sexual behaviors is a means towards controlling womens' bodies and sexuality, which is pervasive in Western societies. The mechanism through which this control is made possible is the discursive powers of the medical

community. Discourse can be defined as the general "conversation" around a social topic. Discursive power, of which the medical community has a great deal, is the ability to have perceived authority on a topic and create a legitimized and widely accepted stance on that topic. Irvine points out how "historically, physicians have played a significant role...in defining the existence, appropriateness, and ideal object of sexual desire or passion" (Irvine, 1997). The occurence of the medical community dictating an "ideal object of sexual desire" is evident in Drescher's analysis of the DSM's previous treatment of homosexuality. Presently, with the issue of a hypersexuality disorder, the feminist perspective informs that this may be a result of a medical authority with plenty of discursive power constructing an "appropriatness" for sexuality. The creation of an "appropriate" array of behaviors is a way of creating restrictive prescribed sexual boundaries.

The construction of "appropriate" sexuality leads to women's sexual behavior being judged more harshly, even by women themselves. In a study cited by Joanniedes, it is revealed that women whose sexual behavior diverges from gendered sexual prescriptions, namely by having high sex drives and/or having sex with other women, sometimes feel that their own behavior is unacceptable. These women therefore they may diagnose themselves based on their behavior *as women,* even if this behavior would be acceptable for a man to engage in. Joannides summarizes this point by saying "self-recrimination is not an unusual consequence when people with traditional beliefs experiment with nontraditional behaviors" (Joannides, 2011). The self-recrimination experienced by delving outside the realm of "traditional" behaviors is unwarranted, as the feminist perspective dictates that "average" or "appropriate" sexual behavior does not exist and sexuality is a social construct. Irvine writes: "if we accept that there is no natural or instictive sexuality (about which we can determine what is too much or too little), it is then clear that we invent sex" (Irvine, 1997). Clearly, this statement asks the reader to accept a huge assumption, that sex is an "invented" construct. Critics may cite the lack of concrete research to support such a claim, however, for the

purposes of examining hypersexuality from a diverse array of perspectives, it is important to acknowledge and respect this feminist theoretical framework.

HYPERSEXUALITY AS MENTAL ILLNESS: STANDING ALONE OR SYMPTOM OF A GREATER PROBLEM

While the existence of problematic sexual behavior cannot go unacknowledged, the appropriate positioning of sexual behavior within the DSM is a hotly contested issue. The DSM is a body of work with incredible influence and discursive power in the US medical community and subsequently society as a whole. The fact that hypersexuality disorder was proposed to be added in the most recent edition of the DSM and this proposal was rejected provides evidence for some hindsight on the part of the powers responsible for defining disorders in this powerful manual. Rory Reid and Martin Kafka discuss the controversy surrounding this decision, and explore the evidence that may indicate if and when it may be appropriate to show clinical consideration for sexual behavior. Reid and Kafka draw on several schools of thought, primarily that mental illness needs to be “statistically deviant and biologically disadvantageous” (Reid & Kafka, 2014). The categorization of hypersexuality within the criteria of being “statistically deviant” is difficult due to the lack of widespread and honest research on the topic of sexual behavior. Without a comprehensive picture of statistically “average” sexual behavior, there is no way of determining a cutoff for “statistically deviant” sexual behavior and no way of defining hypersexuality. Another significant point made by several researchers is that comorbidity between criteria for hypersexuality and other psychological disorders is very high (Reid & Kafka, 2014). High comorbidity may be indicative of problematic sexual behavior being a component of *other* disorders, often being used as a coping mechanism as part of a greater emotional dysregulation (Reid & Kafka, 2014). This position, that of hypersexuality being clinical in nature but as a symptom of other mental disorders, is echoed by Jason Winters in his *Archives of Sexual Behavior* piece: “the repeated pattern of sexual

urges, fantasies, and behaviors is not a symptom of its own distinct disorder...it may simply be a matter of identifying better coping strategies rather than treating a distinct sexual disorder" (Winters, 2010). Both Reid & Kafka and Winters explore the idea that sexual dysregulation may be a symptom, rather than an isolated disorder. This theory is further corroborated by a study which examined "25 participants who reported sexually compulsive behaviour and found that 88% of the participants also met diagnostic criteria for...anxiety and mood disorders" (Zhang, 2012). The work presented by these three publications, by acknowledging the existence of problematic sexual behaviors but framing it as part of a constellation of symptomology for other disorders, may provide one avenue towards consolidating the different perspectives on this controversial diagnosis.

IMPLICATIONS FOR THE INDIVIDUAL: HOW A DIAGNOSIS COULD PROVE HELPFUL

Whatever biased social pressures and motivators may lead to sexual pathologization, this paper would be remiss if it did not address the needs of actual individuals who seek treatment because of sexually-charged distress. For a myriad of social and clinical reasons, hypersexuality should not be pathologized and categorized as a disorder. However, what this position may fail to take into account is the very real presence of individuals who do seek out help for what they personally perceived as dysfunctionally high levels of sexual behavior. It may be argued whether the problematic nature of an individual's sexual behavior is truly disordered or a form of "self recrimination" as referenced by Joannides. Yet the fact remains that people *do* seek relief, and this piece would be remiss if it did not address the ways treating sexual behavior as a disorder with available treatment paradigms may be useful to suffering individuals. While describing sexual disorders and being socially constructed, Irvine also concedes that "scores of people report relief and validation from the desire disagnoses" (Irvine, 1997). While the pathologization of sexual behavior serves to reinforce prescribed boundaries and can enable bigotry, an examination of the impact when distressed individuals receive a diagnosis may be more positive. Irvine suggests the

purpose of a diagnosis can be to "offer the hope of achieving 'normalcy' to those who experience their sexual desire as either inadequate or out of control" (Irvine, 1997). Much like an individual who experiences physical symptoms may feel relief when finally given a diagnosis which explains these, someone who is, by their own account, sexually out of control may feel similarly.

Similar to a medical diagnosis, framing sexual behavior within an addiction model may help individuals find support and acceptance. In a sample of self-identified sex addicts: "more than 94% of the participants in this investigation reported failed attempts to stop or reduce their sexual desire or behaviours and 98% reported three or more withdrawal symptoms, such as depression, insomnia and fatigue" (Zhang, 2012). The language used in this passage, such as the term "withdrawal," or the process of having "failed attempts" at stopping, reflects language used in addiction recovery groups. Thus, the presence of an addiction model may make access to help and support easier for individuals. A *Sex Addiction and Compulsivity* article written by Kenneth Adams and Donald Robinson suggest that "participation in a support group such as Sex Addicts Anonymous (Parker & Guest, 1999) allows the addict to expose shameful events in an accepting atmosphere" (Adams & Robinson, 2001). Adams & Robinson's treatment paradigm is centered around an addiction support model, but also around the concept of shame reduction. This is important given the information presented thus far regarding the powerful role that society and discursive institutions play in the creation of sexual boundaries. Violating prescribed boundaries may create feelings of shame, and "this core shame needs to be felt and processed through and new beliefs about the self...must be created" (Adams & Robinson, 2001). Regardless of the damaging implications of creating a hypersexuality disorder, persons struggling with their sexual behavior should be addressed and an addiction paradigm and shame -reduction treatment option may be a viable solution.

CONCLUSION:

The evidence presented in this paper serves to support the argument that the proposed establishment of a hypersexuality disorder in the DSM would be misguided and heavily influenced by social norms and individual value systems. Joannides illuminates the professional and personal factors that could lead to problematic between-clinician inconsistencies in hypersexuality diagnostic practices. Through the writings of Drescher and Moser, the pathologizing and later depathologizing of homosexuality is used as an illustrative example of the potentially damaging power of the DSM. Discursive power is a topic discussed by Irvine and Moser when addressing the propagation of social normativity and creation of sexual boundaries on the part of the medical institution. Based on the clinical perspective and feminist rhetoric presented throughout this paper, it may be impossible to extricate socially prescribed norms and value systems from a proposed hypersexual disorder. This provides support for the aforementioned argument, and touches on themes within the research questions, such as how value systems and authority impact the perception of sexual behavior. In addressing people who seek help for sexual distress, Adams & Robinson stress that the support offered by 12 step addiction support groups and treatment focusing on shame reduction may be effective. The seeming contradiction between invalidating hypersexuality disorder and addressing individuals seeking help for sexual behavior may be consolidated by viewing hypersexual behavior as a symptom of other disorders. This viewpoint is supported by comorbidity research presented by Zhang as well as commentary by Reid & Kafka and Winters. While this paper focuses on critiquing the construction of hypersexuality disorder, the themes and research presented throughout have broader implications. The discursive power of the institution of medicine, and the ways in which the medical field can be influenced by personal values and social normativity, should be taken into consideration any time a potential diagnosis seeks to place limits on human behavior.

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