Evidence Informed Treatment of Compulsive Sexual Behavior Disorder: A Strength Based Approach

Drew A. Kingston, Ph.D., ATSAF

Liam E. Marshall, Ph.D., ATSAF

liam@rockwoodpsyc.com

ROCKWOOD PSYCHOTHERAPY & CONSULTING

UNIVERSITY OF TORONTO

CONSIDERATIONS

- Much heterogeneity amongst sex offenders with CSBD
- Non-SO clients presenting with CSBD are heterogenous
- Lack of evidence base upon which to determine best treatment approach – SA, SLAA, SAA, CBT, etc.
- Difficulties in diagnosis
  - Not in DSM
- Measures vary primarily based on view of aetiology

Critical issues related to both reducing risk for future sexual offending and managing CSBD

what is the overlap and differences between sexual offending criminogenic issues and features of CSBD?

Possible Path Model to CSBD

(Based on Marshall & Marshall, 2000)

Early Adverse Experiences

Disrupts Attachment Security, Creating Vulnerability

Sexual Behavior Highly Rewarding in Unrewarding Environment

Conditioning Processes Enhance & Direct Sexual Expression

Poor Relationship & Coping Skills Further Need for Seeking Sex

POSSIBLE IMPLICATIONS FOR TREATMENT OF HYPOTHETICAL MODEL

- Trauma
- Attachment Anxiety & Avoidance
- Intimacy deficits
- Loneliness
- Jealousy
- Low Self-esteem
- Poor Coping Skills
- Sexual knowledge and beliefs
- Feelings of Shame
- Motivational Issues
- Poor Emotional Self-Regulation

CRIMINOGENIC ISSUES IN SEX OFFENDERS

Sexual factors

- sexual preoccupation
- sexual interests in children
- Sexual interest in violence

Relationship problems

- lack of intimacy
- insecure attachment
- emotional loneliness

Cognitive factors

- emotional congruence with children
- hostility towards women
- lack of concern for others
- offence supportive attitudes

Self-regulation issues

- emotional dysregulation

Low self-esteem/shame

OVERLAPPING FEATURES OF CSBD & SEX OFFENDING

- Substance abuse
- Childhood or Adolescent Sexual Abuse
- Preoccupation with Sex
- Coping Using Sex
- Shame
- Intimacy Deficits/Relationship Difficulties
- Cognitive Distortions
- Mood Fluctuations
- Low Self-Esteem
- Continue Behavior Despite Negative Consequences
- High Religiosity
- History of Emotional Abuse
- Comorbid Mental Health Problems

OUR RESEARCH ON CSBD IN SEX OFFENDERS: PREVALENCE

	Study					
	1	2	3	4		
Measure	SAST	SAST	SAST	SAST	SR	Overall**
Sexual Offenders	35%	43%	38%	30%*	16%*	36%
Child Molesters	43%	33%		35%	15%	37%
Rapists	10%	53%		15%	16%	26%
Community	13%	12%	16%	8%*	26%*	12%

Notes: *No relationship between scores and BIDR
**Overall percentages do not include SR (Self-Report)

OUR RESEARCH ON CSBD IN SEX OFFENDERS: CORRELATES

- Co-morbidity
  - No r between CSBD and alcohol or other drug problems
- No r with Psychopathy
- CSBDs report higher shame & guilt
- Attachment
  - SOs with CSBD = Preoccupied
  - Community with CSBD = Fearful
- SOs with CSBDs greater problems with schema

OUR RESEARCH ON CSBD IN SEX OFFENDERS: CORRELATES

- Sexual Behavior – all Ss with CSBD
  - No diffs: frequency, age of onset, or diversity of sex behaviors
  - CSBDs more unconventional thoughts, fantasies, & urges
  - But no more likely to engage in these behaviors
- SOs with CSBD
  - report using rape and CM as coping strategies
  - reduce conventional sexual outlets
  - increased rates of masturbation to unconventional sex

SUMMARY OF OUR RESEARCH TO DATE

- CSBDs appear to withdraw from others and prefer impersonal sex
- This withdrawal from others appears to be related to negative view of self (attachment anxiety) and feelings of shame and guilt about sexual behaviour
- It may be that sexual offences occur in those CSBDs who desperately attempt to achieve sexual satisfaction from deviant sexual desires

A THERAPEUTIC STYLE THAT WORKS WITH MEN WHO HAVE COMMITTED SEXUAL OFFENCES AND HAVE CSBD

WHAT DOESN'T WORK?

- Only targeting deviance
- Doing things because that is the way we have always done them
- Addressing non-criminogenic targets
- Therapist being aggressively confrontational
- Kicking people out of group
- Therapist being unchallenging
- Over-treating
- Relapse-prevention on its own
- Punishment/Shaming

MOST EFFECTIVE WHEN…(GANNON ET AL., 2019)

Important program variables

- Group vs. individual/combined:
  - Group = Better outcome
- Staff Supervision vs. none:
  - Supervised = Better outcome
- Arousal Reconditioning vs. none:
  - Have AR = Better
- Polygraph use:
  - No Polygraph = Better outcome

SOME TREATMENT PROGRAM OUTCOME DETERMINANTS

- Refusers
  - Flooding therapy
- Dropouts
  - High rates of dropouts in offender programs
- Gets it
  - How much is enough treatment?

SOTP DELIVERY CONSIDERATIONS

- Guide versus Manual
- Client's perspectives considered
- Therapeutic alliance/group climate
- Therapist Characteristics (WERD)
- Treatment approach – CBT, Strength-Based
- Risk/Needs/Responsivity

SOME OF THE GUIDING THEORIES

- Risk, Needs, Responsivity
- Good Lives Model
- Motivational Interviewing
- Desistance theories
- Positive psychology

TREATMENT STRATEGIES

Three approaches have typically been used in sex offender treatment:

- Confrontational approach
- **Motivational approach**
- Unchallenging approach

STRATEGIES TO ADDRESS CSBD IN INDIVIDUALS WHO HAVE COMMITTED SEXUAL OFFENSES

Based on:

A TREATMENT PROGRAM FOR THOSE WHO HAVE SEXUALLY OFFENDED AND PRESENT WITH CSBD: A MANUAL

By

Liam E. Marshall & Drew Kingston

www.rockwoodpsyc.com

STRENGTHS-BASED APPROACH TOPICS

- Self-Esteem
- Hope
- Guilt
- Empathy
- Coping
- Relationships
- Healthy sexuality
- Motivation
- Approach goals
- Knowledge
- Agency
- Autonomy
- Mastery
- Relatedness
- Creativity
- Mindfulness
- Relaxation

ROCKWOOD PROGRAM

MOTIVATION & ENGAGEMENT	PRIMARY TREATMENT	FUTURE LIFE STRATEGIES

1. LEAD-UP TO OFFENCE
2. AUTOBIOGRAPHY
 	
Goals and Optional Exercises
• Orientation to treatment
• Enhancing self-esteem
• Reducing shame
• Improving coping and mood management
	3. EMPATHY/VICTIM HARM
	4. OFFENCE ANALYSIS
	• Background Factors
	• Immediate Factors
	
	RELATIONSHIP SKILLS
	• Nature and advantages of intimacy
	• Problems of loneliness
	• Attachment styles
	• Communication
	• Jealousy
	SEXUALITY
	• Healthy sexual functioning
	• Maximizing sexual satisfaction
	• Reducing deviant interests
	  ○ behavioural strategies
	  ○ pharmacological interventions
		5. GOOD LIFE PLANS
		• Goal setting
		6. SELF-MANAGEMENT PLANS
		• Approach goals
		• Limited RP plans
		• Warning signs for self and others
		7. SUPPORT GROUPS
		• Family and friends
		• Professionals
		• Colleagues
		8. RELEASE PLANS
		• Accommodation
		• Employment
		• Leisure

OUTLINE OF MANUAL

INTRODUCTION

- How to use the manuals
- Reporting Outcome

PROGRAM

- Phase I. MOTIVATION & ENGAGEMENT ENHANCEMENT
  - Overview of Phase I for treatment providers
  - CORE & OPTIONAL EXERCISES
- Phase II: CORE TREATMENT ISSUES
  - Overview of Phase II for treatment providers
  - CORE & OPTIONAL EXERCISES
- Phase III: PREPARING FOR THE FUTURE
  - Overview of Phase III for treatment providers
  - CORE & OPTIONAL EXERCISES

PROGRAM FOR SEX OFFENDERS WITH CSBD

PHASE OF TREATMENT	GOAL	EXERCISES
ENHANCING MOTIVATION	PROBLEM IDENTIFICATION	• Safety Plan (if needed - community) • Lead-up to problem
	BACKGROUND INFORMATION	• Autobiography
CORE ISSUES	IMPROVE FUNCTIONING	• Relationship Issues • Healthy Sexuality • Unique Factors
BUILDING A BETTER FUTURE	INTEGRATION	• Risk Factors & Warning Signs • Goal setting (GLM)
	MAINTENANCE	• Self-management • Future plans

MOTIVATION FOR CHANGE

- Although community CSBDs are usually self-referred, actual motivation to change is low
- Most common reason for non-SO CSBDs coming to our community clinic was spousal insistence
- High rates of dropout
- Sexual behaviors that are used to cope with difficulties are both positively and negatively rewarding

SAFETY PLAN – PART 1

SEXUAL BEHAVIOURS THAT POSE A RISK TO SELF OR OTHERS	OTHER SEXUAL BEHAVIOURS

Circle behaviours that are of minimal risk in which to continue to engage and cross out those that will be avoided, at least until the end of treatment

SAFETY PLAN – PART 2

If I get urges to engage in a high risk behaviour, I can call someone:		
Name	Phone #	Alternate Phone #

SAFETY PLAN – PART 3

If I get urges to engage in a high risk behaviour, these are the things I can do to distract myself when I am at home, work, other places:	
1	
2	
3	
4	
5	

COPING STRATEGIES

- Emotional
  - Crying, Pathological Grieving, Anger, Fretting
- Avoidance
  - Watching TV, Working, Playing games, Exercising
  - Alcohol, Drugs, Sex
- Task-focused
  - Trying to solve the problem

BARTHOLOMEW'S DIMENSIONAL MODEL OF ATTACHMENT

VIEW OF OTHERS Attachment Avoidance	VIEW OF SELF Attachment Anxiety: -	VIEW OF SELF Attachment Anxiety: +
+	PREOCCUPIED	SECURE
-	FEARFUL	DISMISSIVE

MODIFYING SEXUAL INTERESTS

BEHAVIORAL

1. Aversive therapy
   - Electric shock
   - Olfactory
   - Ammonia
   - Covert sensitization
2. Masturbatory reconditioning
   - Thematic shift
   - Satiation

MEDICAL

1. Hormonal
   - Medroxyprogesterone Acetate (Provera)
   - Cyproterone Acetate (Androcur)
   - Leuprolide (Lupron)
2. SSRIs
   - Fluoxetine (Prozac)
   - Sertraline (Zoloft)

DOES IT WORK?

ROCKWOOD'S SOTP

Refusers	3.8%
Drop-outs	4.2%
Completions	95.8%

OUTCOME FOR ROCKWOOD PROGRAM - 2005

Reoffence	Treated* (N = 535)	Expected**
Sexual	3.2%	16.8%
General	13.6%	40.0%

*Mean follow-up = 5.4 years

**Based on Static-99 and S.I.R.

OUTCOME FOR ROCKWOOD PROGRAM - 2015

Reoffence	Treated* (*N* = 579)	Expected**
Sexual	5.4%	23.6%
Violent	8.1%	33.4%

*Mean follow-up = 9.62 years

**Based on Static-99R

ROCKWOOD PROGRAM VERSUS TAU & UNTREATED 8-YEAR FIXED FOLLOW-UP, **SEXUAL RECIDIVISM**

Treatment Program	Recidivism Rate
Untreated (N = 104)	20.2%
Treatment As Usual (N = 616)	10.7%
Rockwood Program (N = 381)	4.2%
Odds Ratio, Rockwood versus:	Untreated = .17*** (83%)
	TAU = .37*** (63%)

Olver et al. (2020). A Long-Term Outcome Assessment of the Effects on Subsequent Reoffense Rates of a Prison-Based CBT/RNR Sex Offender Treatment Program With Strength-Based Elements. *Sexual Abuse, 32,* 127-153.

ROCKWOOD PROGRAM VERSUS TAU & UNTREATED **HIGH RISK ONLY**

Treatment Program	Recidivism Rate
Untreated (N = 34)	35.3%
Treatment As Usual (N = 121)	17.4%
Rockwood Program (N = 44)	11.4%
Odds Ratio, Rockwood versus:	Untreated = .24*** (76%)
	TAU = .61 (39%)

Olver et al. (2020). A Long-Term Outcome Assessment of the Effects on Subsequent Reoffense Rates of a Prison-Based CBT/RNR Sex Offender Treatment Program With Strength-Based Elements. *Sexual Abuse, 32,* 127-153.

A cost–benefit analysis of a treatment program for adult males who have offended sexually

- Marshall & Marshall (2021). *Journal of Sexual Aggression*, 27, 313-318, DOI: 10.1080/13552600.2021.1934133

COST-BENEFIT ANALYSIS

- Observed reoffence rate = 4.2% (N=16/381)
- Expected reoffence rate = 20.2% (N=77/381)
- Reduction in number of reoffenders = 61

- Cost of recidivism per offender = $200,000 ($400,000-2020*)
- Cost of SOTP per offender = $3,000

*1990 $1 is about $2 today – estimates vary between $1.71 and $2.07

COST SAVINGS TO JUDICIAL SYSTEM

	Calculation	Total (1990 $)	Total (2020 $)
Savings	61 reoffenders prevented	$12,200,000	$24,400,000
Cost of SOTP	381 x $3,000	$1,143,000	
Total Savings	(Savings – Cost of SOTP)	$11,057,000	$23,257,000

SUMMARY

- A significant proportion of those who commit sexual offences also have CSBD problems
- There is much overlap between sexual offender criminogenic risk factors and the characteristics of CSBD
- The Rockwood SOTP appears to be effective in reducing reoffending in sexual offenders who have CSBD
- Adding components to the Rockwood program that can help those with concurrent CSBD may help to further reduce reoffending

Evidence Informed Treatment of Compulsive Sexual Behavior Disorder: A Strength Based Approach

QUESTIONS?

Drew A. Kingston, Ph.D., ATSAF
dkingston@hopeprogram.biz

Liam E. Marshall, Ph.D., ATSAF
liam@rockwoodpsyc.com

Evidence Informed Treatment of Compulsive Sexual Behavior Disorder: A Strength Based Approach

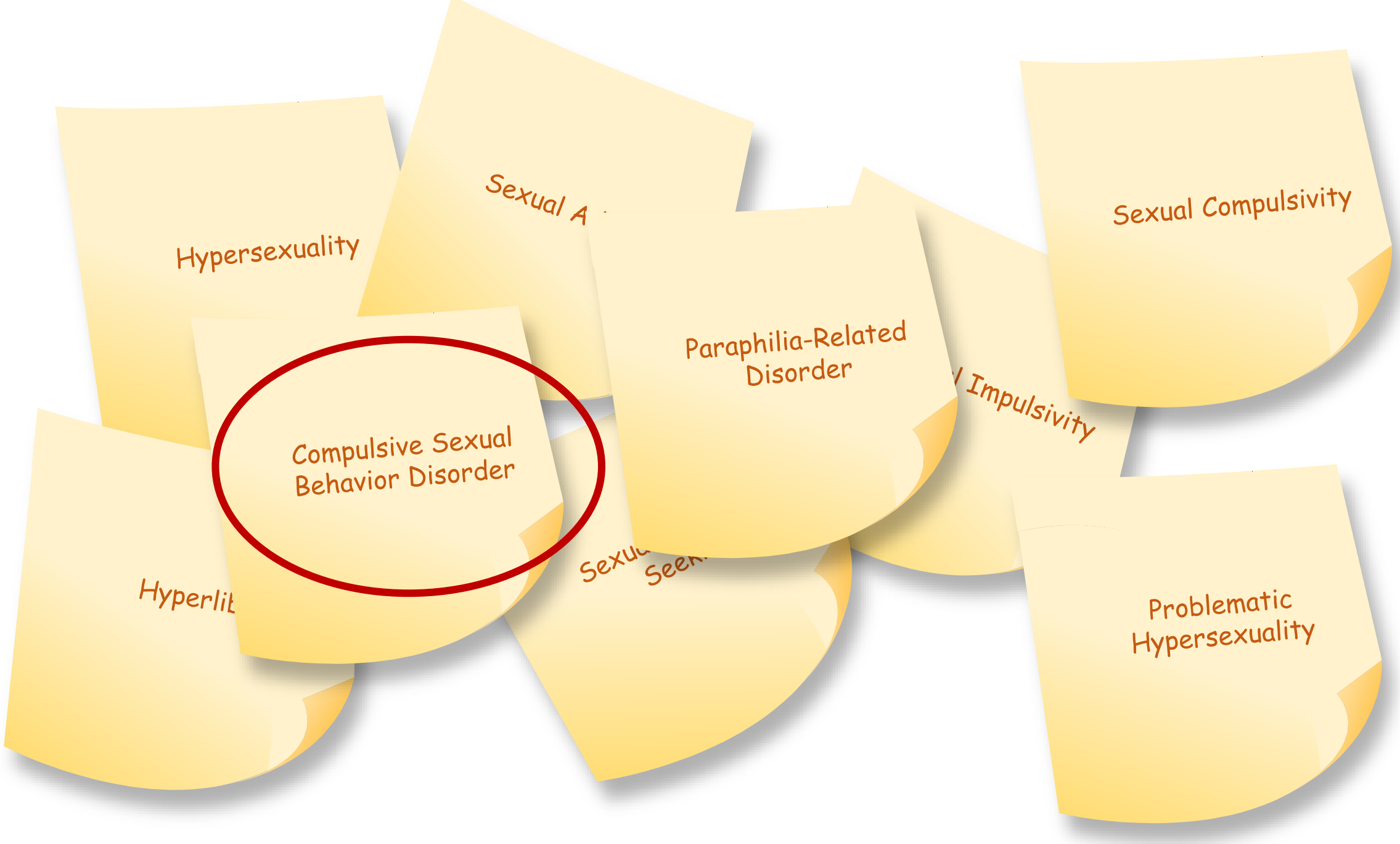
Drew A. Kingston, Ph.D., ATSAF

Liam Marshall, Ph.D., ATSAF

HOPE PROGRAM

McMaster University

What do we call it?


Hypersexuality
Sexual A
Paraphilia-Related Disorder
Impulsivity
Sexual Compulsivity
Compulsive Sexual Behavior Disorder
Hyperli
Problematic Hypersexuality

Controversy

- Value laden concept
- Disorder vs symptom
- Pathologizing healthy, yet atypical, sexual behavior
- Lack of research
- Clinical implications

(Giles, 2006; Levine & Troiden, 1988; Ley, 2012)

Defining CSBD

- Two essential elements:
  - A set of symptoms
  - Impairment

Symptoms:

Objective/Observable

- Frequency of sexual activity (Solo and relational)
- Total Sexual Outlet (TSO) (Kinsey et al., 1948)
- TSO ≥ 7 = Hypersexuality (Kafka, 1997)

Subjective/Experiential

- volitional impairment

Manifestations

- Solo vs relational sexual activities
- Paraphilic vs non-paraphilic

Manifestations

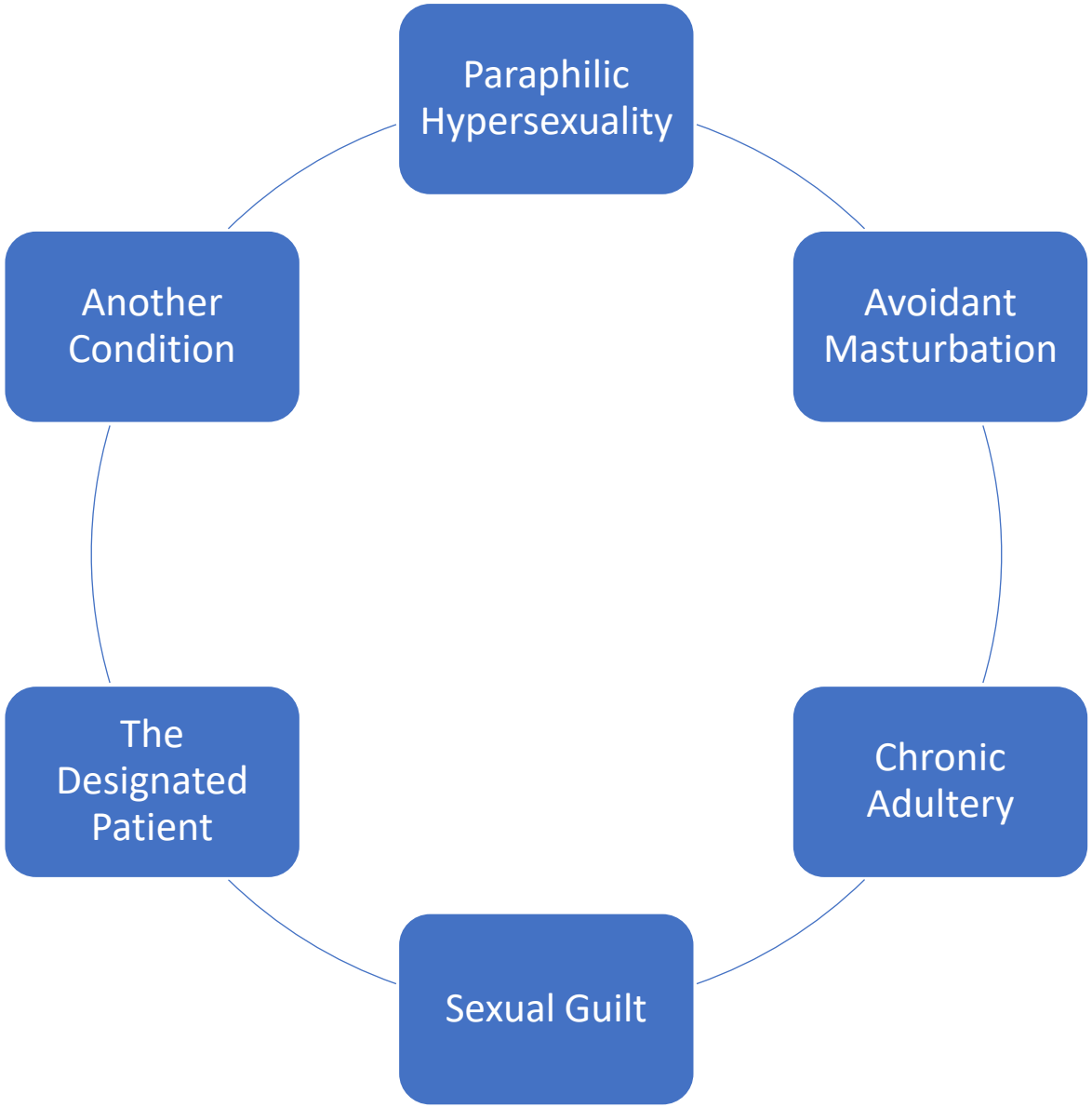
- **Solo vs relational sexual activities**
- Paraphilic vs **non-paraphilic**

Manifestations

- **Solo vs relational sexual activities**
- Paraphilic vs **non-paraphilic**

- Compulsive masturbation (70%)
- Pornography dependence (50%)
- Protracted promiscuity (50%)
- Telephone sex (25%)
- Severe sexual desire incompatibility (12%)
- Cybersex, strip clubs

(Kafka, 2010)



(Cantor et al., 2013)

Conceptualization

Sexual Compulsivity vs Impulsivity

Sexual Compulsivity

- Obsessions are intrusive and associated with anxiety/tension
- Sexual behavior intended to reduce anxiety/distress

Sexual Impulsivity

- Predisposition toward rapid, unplanned reactions
- Diminished regard for negative consequences
- Lack of control over sexual impulses
- Emphasis on increasing positive emotional states

(see Kingston & Firestone, 2008)

Sexual Addiction

- Maladaptive pattern of substance use with impaired control/adverse consequences
    a) Impaired control
    b) Social impairment
    c) Risky use
    d) Pharmacological criteria
- Pathological relationship with a mood-altering behavior (e.g., sex, shopping)

Substance Use Disorder Criteria

1. Substance is taken in larger amounts over longer periods
2. Multiple, unsuccessful efforts to control use
3. More time spent obtaining, using, or recovering from the substance
4. Intense desire to obtain the drug (craving)
5. Results in failure to fulfill major obligations
6. Continued use despite adverse consequences
7. Social activities may be given up or reduced
8. Engaging in use in risky situations
9. Continued use despite harmful effects caused by the substance
10. Needing markedly increased dose (tolerance)
11. Withdrawal symptoms

Substance Use Disorder Criteria

1. Substance is taken in larger amounts over longer periods
2. Multiple, unsuccessful efforts to control use
3. More time spent obtaining, using, or recovering from the substance
4. Inte
5. Res
6. Con
7. Soc
8. Eng
9. Contin
10. Needing markedly increased dose (tolerance)
11. Withdrawal symptoms

Impulsivity and positive reinforcement

Compulsivity and negative reinforcement

Dual-Control Model

- Individuals vary in their propensity for sexual excitation and sexual inhibition
- The effects of excitatory and inhibitory processes are mediated by genetics, learning, etc.
- Inhibition of sexual response is adaptive
  - When sexual activity is dangerous
  - When a nonsexual challenge occurs
  - When excessive involvement distract from other functions

The Sexual Inhibition/Sexual Excitation Scales

- 45 items
- One Sexual Excitation factor (*SES*)
  - "When I think of a very attractive person, I easily become aroused"
- Two inhibition-related factors:
  - Threat of performance failure (*SIS1*)
    - "If I feel that I'm expected to respond sexually, I have difficulty getting aroused"
  - Threat of performance consequences (*SIS2)*
    - *"If I realize there is a risk of catching a sexually transmitted disease, I am unlikely to stay sexually aroused"*

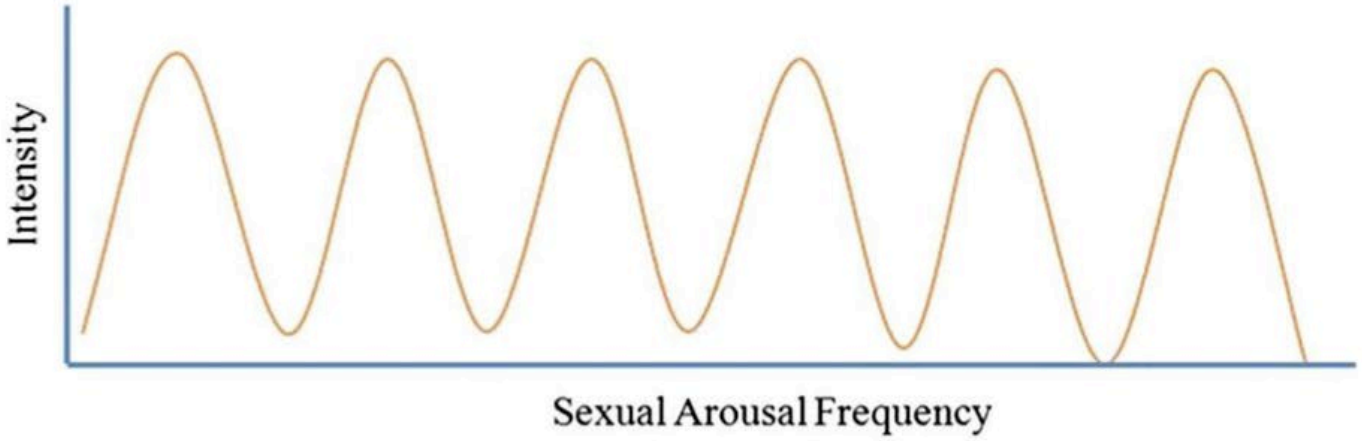
(Janssen, Vorst, Finn & Bancroft, 2002)

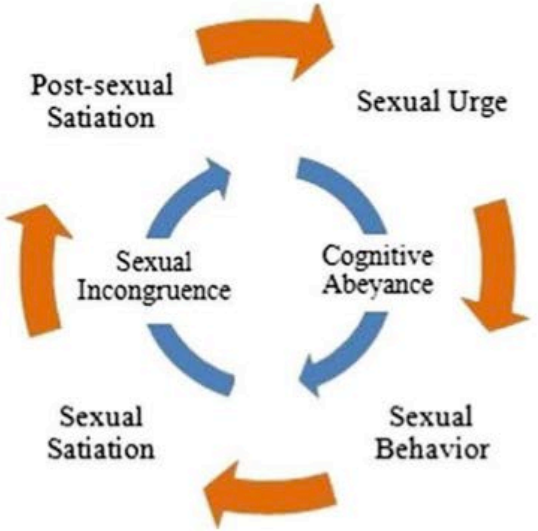
Dual-Control Model findings

- Negative mood states = decreased sexual interest/response
- For some, paradoxical relationship found
  - Mood and Sexuality Questionnaire
  - The relevance of emotional dysregulation
- High SES predicted ”sexual addiction”
- High SES/Low SIS2 predicted high risk sexual behaviors

(e.g., Bancroft et al., 2003, 2009)

Sexhavior Cycle





(Walton et al., 2017a; Walton et al., 2017b; See Kingston 2018 for a critical review)

Relevance

Prevalence

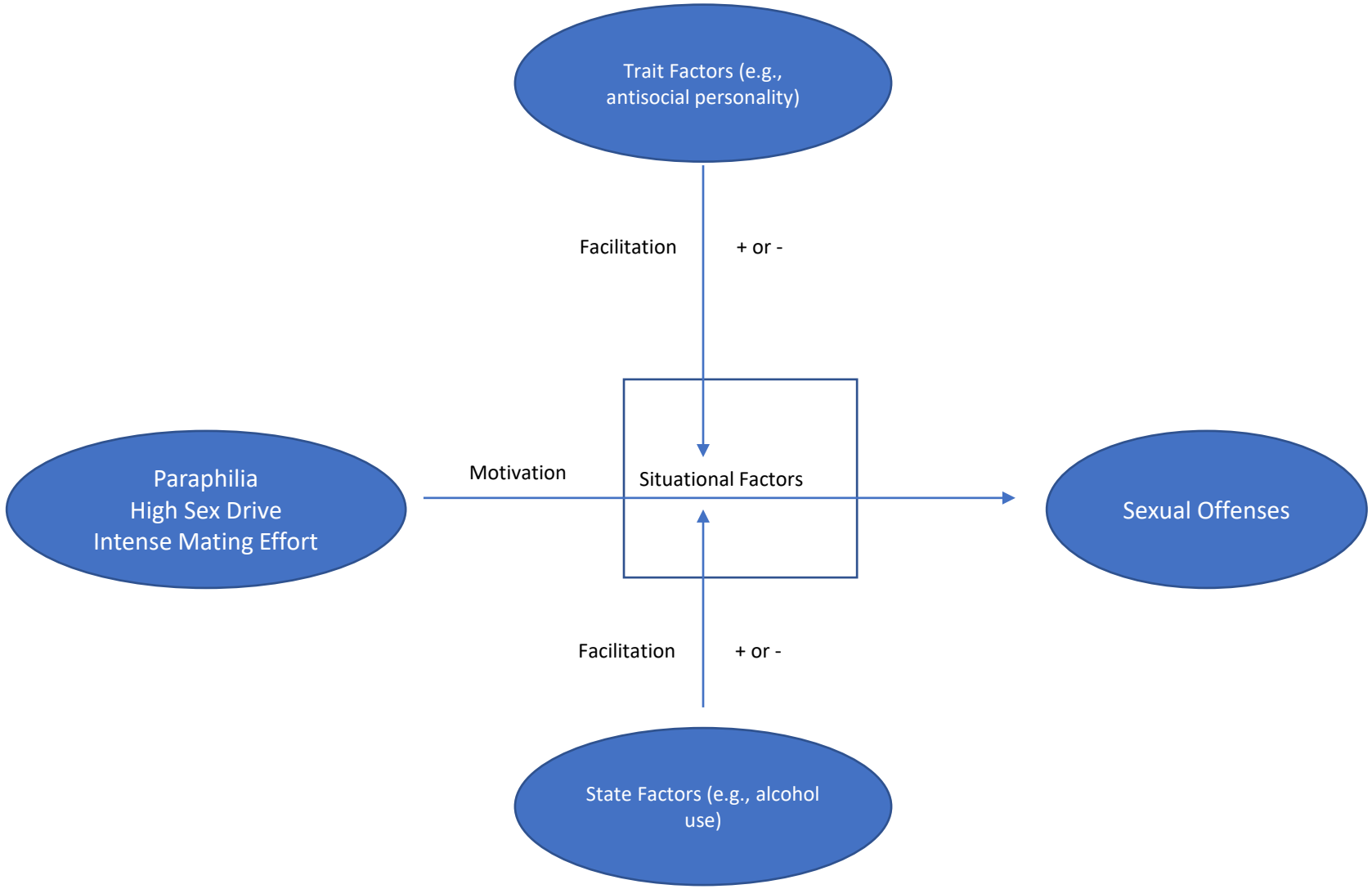
- Prevalence remains elusive (3%-6%)
- Non-clinical samples - 1% - 10% (Böthe et al., 2019; Dickenson et al., 2018)
- Highly prevalent among specific populations
  - HIV infected men – 30% (Parsons et al., 2012)
  - Military veterans – 14% (Kraus et al., 2017)
  - Individual convicted of a sexual offense – 30%-50% (Walter, Knight, Langstrom, 2011; Marshall & Marshall, 2006)

CSBD and Sexual Offending

- Developmental antecedent for sexual aggression
- Criminogenic need
- Risk relevant treatment target
  - STABLE 2007
  - VRS-SO

(Hanson & Morton-Bourgon, 2005; Kingston & Bradford, 2013; Knight & Sims-Knight, 2011; Malamuth, 2003; Olver et al, 2014)

Motivation-Facilitation Model (Seto, 2019)



Assessment and Diagnosis

Definition: Diagnosis

Compulsive Sexual Behavior Disorder **ICD-11**	**Hypersexual Disorder** **DSM-5**
Repetitive sexual activities become a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities	Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other important (non-sexual) goals, activities and obligations

(Gola et al., 2020)

Definition: Diagnosis (Gola, Lewczuk, Potenza, Kingston, Grubbs, Stark, & Reid, 2020)

Compulsive Sexual Behavior Disorder **ICD-11**	**Hypersexual Disorder** **DSM-5**
Repetitive sexual activities become a central focus of the person's life to the point of neglecting health and perso[illegible] interests, activities and resp[illegible]	Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other [illegible]) goals, activities and

Excessive Focus and amount of time spent on sex while neglecting other areas

Definition: Diagnosis

ICD-11	DSM-5
A person makes numerous unsuccessful efforts to significantly reduce repetitive sexual behavior	Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviors.

Definition: Diagnosis

ICD-11	DSM-5
A person makes numerous unsuccessful efforts to significantly reduce repetitive sexual behavior	Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies,

Impaired Control

Definition: Diagnosis

ICD-11	DSM-5
The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behavior causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.	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.

Definition: Diagnosis

ICD-11	DSM-5
The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behavior causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioni	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.

Significant Distress and Impairment in Functioning

Definition: Diagnosis

ICD-11	DSM-5
A person continues the engagement in repetitive sexual behaviour despite adverse consequences.	Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.

Definition: Diagnosis

ICD-11	DSM-5
A person continues the engagement in repetitive sexual behaviour despite adverse consequences.	Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional [illegible].

Continued Engagement Despite Adverse Consequences

Definition: Diagnosis

ICD-11	DSM-5
A person continues the engagement in repetitive sexual behavior despite deriving little or no satisfaction from it	Not Present

Definition: Diagnosis

ICD-11	DSM-5
A person continues the engagement in repetitive sexual behavior despite deriving little or no satisfaction from	Not Present

Compulsive Engagement with Less Sexual Satisfaction

Diagnosis

ICD-11	DSM-5
Not Present	Repetitively engaging in sexual fantasies, urges or behaviors in response to dysphoric mood states or stressful life events

Diagnosis

ICD-11	DSM-5
Not Preser	Repetitively engaging in sexual fantasies, urges nse to dysphoric mood events

Maladaptive Coping/Emotional Dysregulation

Definition: Diagnosis

ICD-11	DSM-5
Distress that is entirely related to moral judgments and disapproval about sexual impulses is excluded	Not Present
Not Present	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)
Paraphilic disorders are excluded	

Definition: Diagnosis

ICD-11	DSM-5
Distress that is entirely related to moral judgments and disapproval about sexual impulses is excluded	Not Present
Not Present	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 dication)
Paraphilic disorders a	

Exclusion criterion due to moral incongruence, exogenous substances, and paraphilic disorders

Diagnostic Options

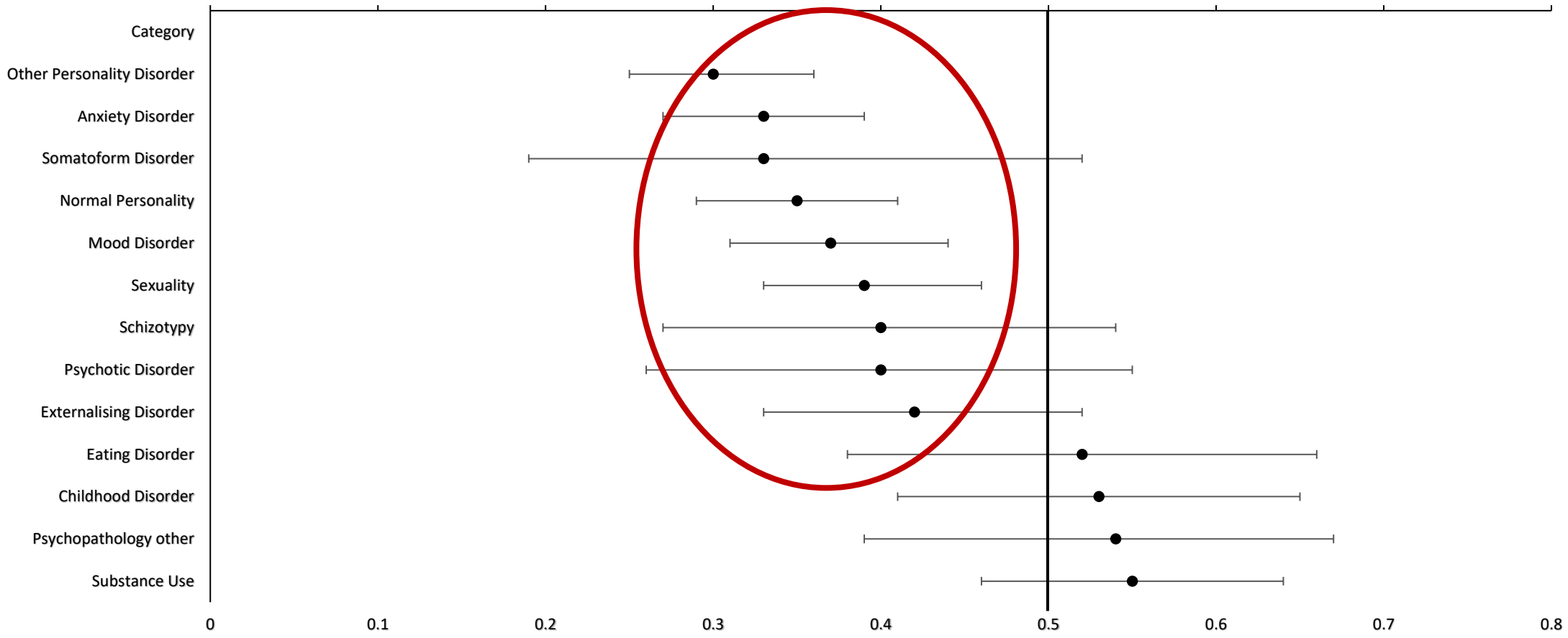
- ICD-11
  - 6C72 “Compulsive Sexual Behavior Disorder”
- DSM-5 (Krueger, 2021)
  1. **F99 “Other Specified Mental Disorder”**
  2. **F91.8 “Other Specified Disruptive, Impulse-Control, and Conduct Disorder, Hypersexuality”**

     Consistent ICD classification as an impulse control disorder

Structure

CATEGORICAL ENTITIES VS CONTINUOUSLY DISTRIBUTED TRAITS

Dimensions vs Categories

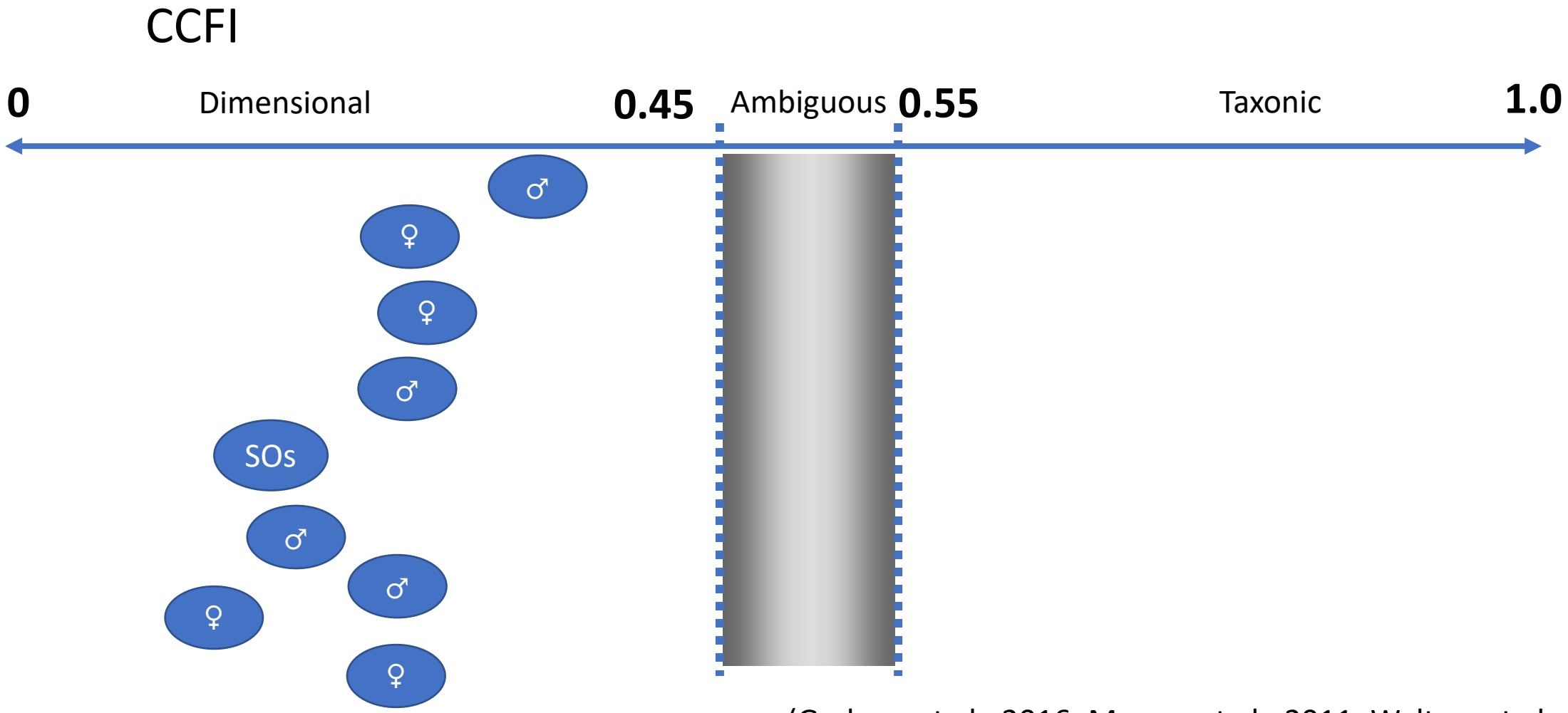


(Haslam et al., 2020)

Dimensional vs categorical?

- Frequently discussed as a taxon:
  - Conceptualizations (e.g., sex addiction)
  - Proposed DSM-5 Criteria (4/5; Kafka, 2010)
  - Total Sexual Outlet (7+ orgasms per week)
  - Assessment measures (SCS ≥ 24; HBI ≥ 53)
- Primary metric -- comparison curve fit index (CCFI)
  - ≤ .45 dimensional
  - .46 - .55 ambiguous
  - ≥ .55 taxonic

Taxometric Research



(Graham et al., 2016; Marcus et al., 2011; Walters et al., 2011)

Archives of Sexual Behavior (2018) 47:2207–2221
https://doi.org/10.1007/s10508-018-1273-9

ORIGINAL PAPER

Understanding the Latent Structure of Hypersexuality: A Taxometric Investigation

Drew A. Kingston[1,2] · Glenn D. Walters[3] · Mark E. Olver[4] · Enya Levaque[5] · Megan Sawatsky[5] · Martin L. Lalumière[2,5]

Received: 22 February 2018 / Revised: 26 May 2018 / Accepted: 5 July 2018 / Published online: 18 September 2018

Abstract
We examined the latent structure and taxonicity of hypersexuality in large university and community samples of male and female respondents. Participants completed the Hypersexual Behavior Inventory (HBI) and Sexual Compulsivity Scale (SCS), each as part of larger anonymous online surveys of sexual behavior. Exploratory factor analyses (EFA) were performed in part to prepare the data for taxometric analysis and also to identify the putative dimensions underpinning each measure. Three latent dimensions were identified from each of the Sexual Compulsivity Scale (dyscontrol, consequences, and preoccupation) and Hypersexual Behavior Inventory (coping, dyscontrol, and consequences). Taxometric analyses of the generated factors using mean above minus below a cut (MAMBAC), maximum covariance (MAXCOV), and latent mode factor analysis (L-Mode) broadly supported a dimensional latent structure for hypersexuality, particularly in female participants. Implications pertaining to the assessment of hypersexuality are discussed.

Keywords Hypersexuality · Taxometric analysis · Latent structure · DSM-5

Introduction

Hypersexuality is characterized by very intense and frequent (or markedly increased) sexual urges or sexual activities that produce distress and/or impairment to the individual. It is often regarded as a symptom of other psychiatric and medical conditions (e.g., bipolar disorder, Parkinson's disease; Vriend et al., 2014), but some have suggested that frequent sexual behavior can cluster with other symptoms, such as loss of control over sexual behavior, the use of sex in response to dysphoric mood, and the continuation of sexual behavior despite adverse consequences, to create a unique psychopathological condition

✉ Drew A. Kingston
dkingston@hopeprogam.biz

[1] HOPE Program, 208-995 Gateway Center Way, San Diego, CA 92102, USA

[2] The Royal's Institute of Mental Health Research, Ottawa, ON, Canada

[3] Department of Criminal Justice, Kutztown University, Kutztown, PA, USA

[4] Department of Psychology, University of Saskatchewan, Saskatoon, SK, Canada

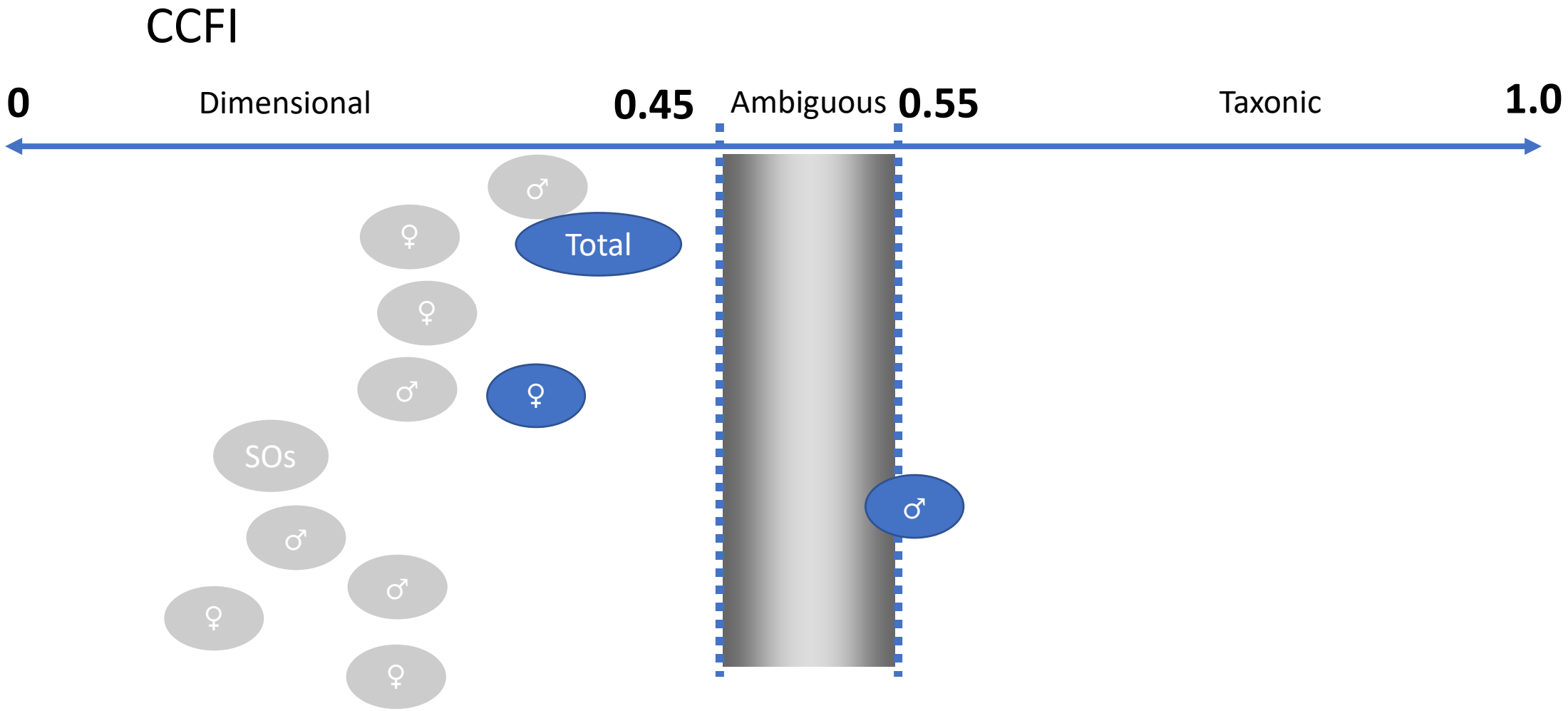
[5] School of Psychology, University of Ottawa, Ottawa, ON, Canada

(Carnes, 1991; Coleman, 1992). Kafka (2010) proposed "hyper-

controversial (Giles, 2006; Ley, 2012) and the academic community is largely divided on whether it should be viewed as a

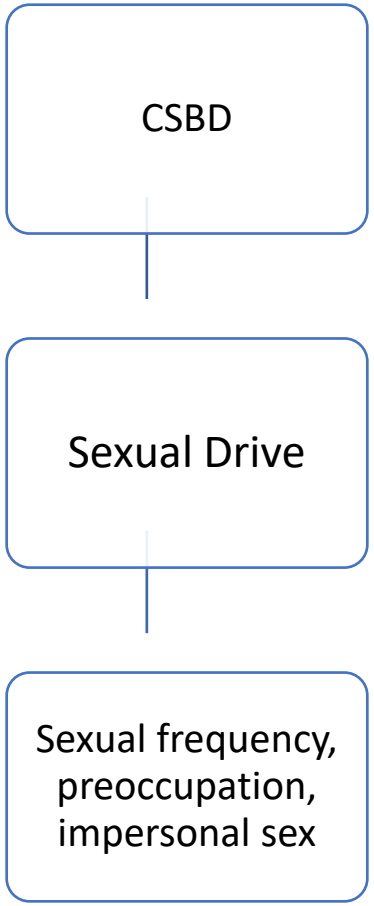
Kingston, D. A., Walters, G. D., Olver, M. E., Levaque, E., Sawatsky, M., & Lalumière, M. L. (2018). Understanding the latent structure of hypersexuality: A taxometric investigation. *Archives of Sexual Behavior.*

Taxometric Research



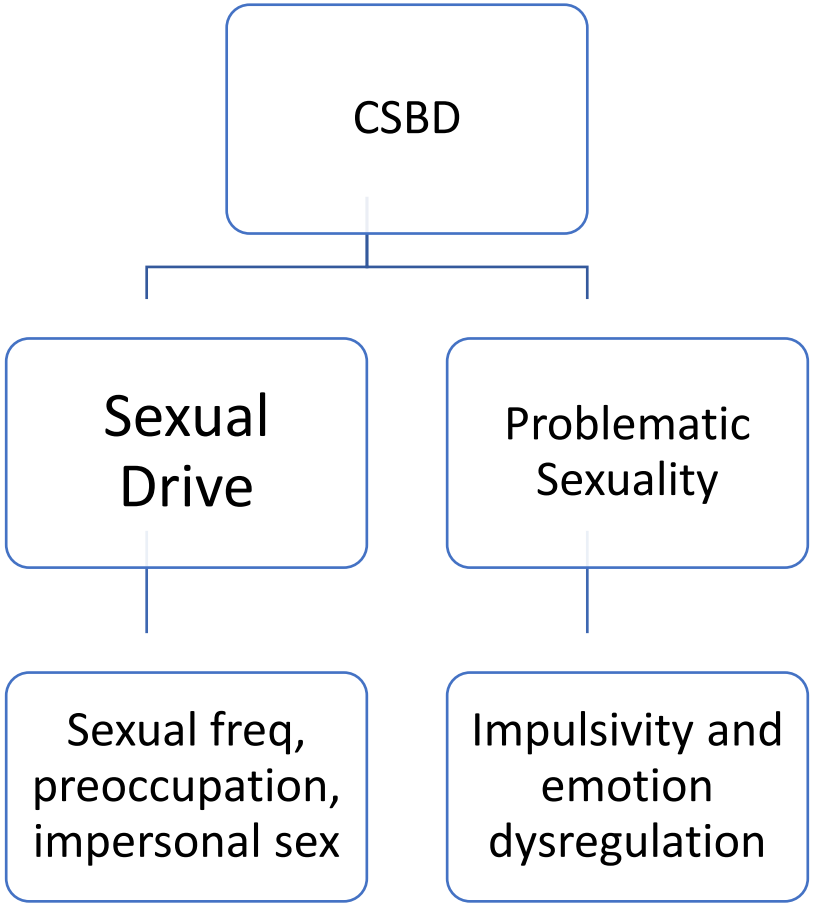
(Kingston et al., 2018)

Dimensions of CSBD



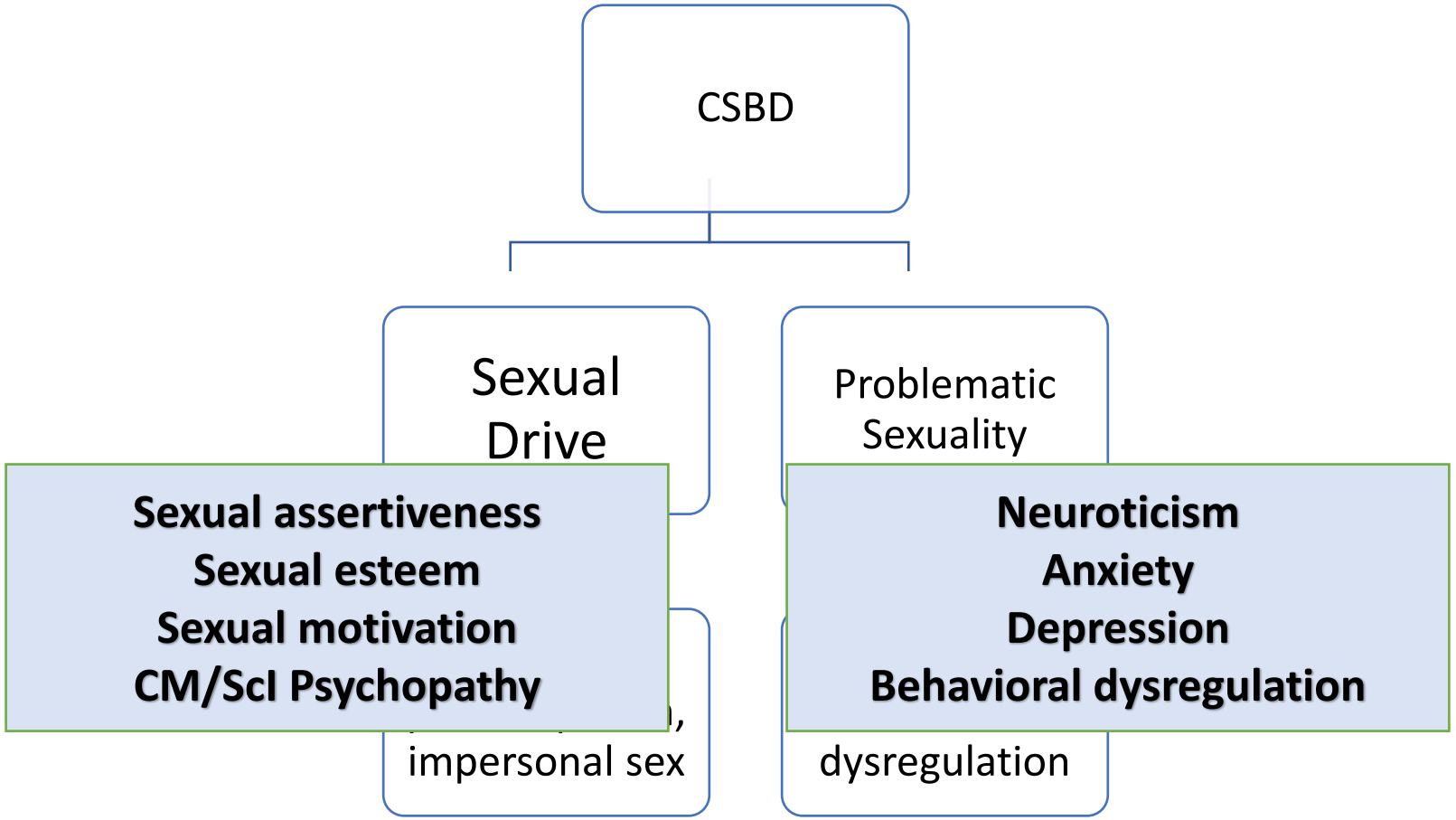
(Winters et al., 2010 Carvalho et al., 2015)

Dimensions of CSBD



(Kingston et al., 2018; Knight & Du, 2021)

Dimensions of CSBD



(Kingston et al., 2018; Knight & Du, 2021)

Norms and metrics

Identifying High Rates of Sexual Behavior (Långström & Hanson, 2006)

- Large adult Swedish sample (*n* = 2,450)
- Hypersexuality = 90th %
  - Masturbation during previous month
    - Men (≥ 15) Women (≥ 5)
  - Pornography use last year
    - Men (≥ 31) Women (≥ 4)
  - Number of sexual partners last year
    - Men (≥ 3) Women (≥ 2)
- Impersonal sex versus sex with a partner
  - Adverse family background, negative health indicators, and life satisfaction

Archives of Sexual Behavior
https://doi.org/10.1007/s10508-021-02241-z

ORIGINAL PAPER

Orgasm Frequency (Total Sexual Outlet) in a National American Sample

Joshua R. Peters[1] · Lesleigh E. Pullman[2] · Drew A. Kingston[3,4] · Martin L. Lalumière[2,4]

Received: 29 May 2020 / Revised: 16 November 2021 / Accepted: 17 November 2021

Abstract

There has been renewed interest in the conceptualization and diagnosis of conditions marked by excessive sexuality. Researchers and clinicians have often utilized orgasm frequency (e.g., total sexual outlet) as an indicator of hypersexuality. Indeed, some have proposed seven or more (7+) orgasms by any means in a typical week as indicating hypersexuality. Most studies utilizing this criterion, however, have examined clinical or judicial samples of men, as opposed to general population samples. The purpose of the current study was to provide representative population data of total sexual outlet (TSO) for people varying in age, relationship status, and sex, while also examining the impact of the phrasing of the questions (i.e., time frame). A total of 1029 participants were recruited online via a Qualtrics panel, consisting of 442 males and 587 females, from diverse regions across the USA. Results indicated that between 10.3 and 16.7% of the sample met the 7+ criterion for hypersexuality, with considerable variation by age, relationship status, sex, and less variation by wording of the question. Results are discussed in terms of the applicability of the 7+ cut-off for identifying elevated TSO. Results from this survey could be useful to researchers and clinicians looking for comparison data for their research and clinical assessment results.

Keywords Total sexual outlet · Orgasm · Sex drive · Hyp

Introduction

At what point does engaging in sexual behavior become e
sive or unhealthy? This question underscores the challen
defining, conceptualizing, and measuring hypersexuality (
ston & Firestone, 2008). Indeed, the existence of hypers
ity as a disorder has been hotly debated (Giles, 2006; G
Heffner, 1998), and it was not included in the fifth edition
Diagnostic and Statistical Manual of Mental Disorders (DS
American Psychological Association, 2013). However, co
sive sexual behavior disorder (CSBD) has been incorpo
in the *International Classification of Diseases, 11th revision*

utilizing a variety of labels such as sexual compulsivity, sex addiction, hypersexuality, and most recently, compulsive sexual behavior disorder. Numerous conceptualizations and measures in this research have considered frequency of sexual activity and associated distress (e.g., Reid et al., 2009, 2012). Researchers and clinicians generally agree that hypersexuality and related constructs are marked by intense and persistent sexual fantasies and urges, impaired control, and frequent sexual behavior

✉ Martin L. Lalumière
martin.lalumiere@uottawa.ca

[1] Department of Psychology, Carleton University, Ottawa, ON, Canada

Peters, J. R., Pullman, L. E., Kingston, D. A., & Lalumière, M. (2022). Orgasm Frequency (Total Sexual Outlet) in a National American Sample. *Archives of Sexual Behavior, 51*, 1447-1460.

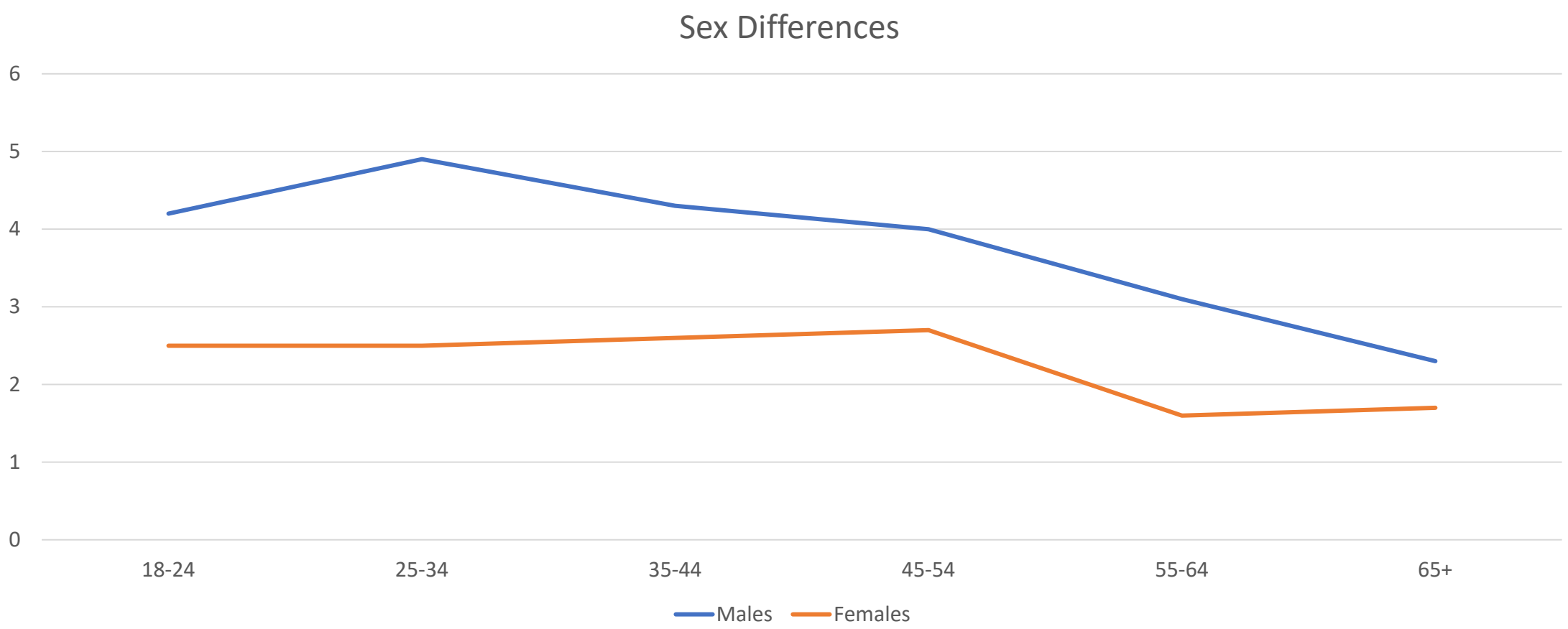
Orgasm Frequency

- Purpose – Provide a representative population data of TSO
  - Varying in age, relationship status, and sex
- N = 1029 from diverse regions of the USA
  - 442 males
  - 587 females
- Diverse population from the USA
  - West – 23%
  - Midwest – 22%
  - South – 36%
  - Northeast – 19%

Orgasm Frequency

- Average TSO
  - 3 per week
  - 10 per month
- Sex Differences (TSO by any means)
  - Females are 2.7 per week
  - Males are 4.2 per week

Orgasm Frequency



Elevated Orgasm Frequency

- 10% to 16% of entire sample reported 7+ orgasms
  - Males = 17% - 25% reported 7+ orgasms
  - Females = 5% - 10% reported 7+ orgasms
- Much higher than the suggested 3-6% prevalence rates
- Higher than Kafka’s goal of 5% - 10% of the population

Establishing Canadian metrics for self-report measures used to assess hypersexuality

Drew A. Kingston[1,2*], Mark E. Olver[3*], Enya Levaque[4], Megan Sawatsky[4], Michael C. Seto[2], and Martin L. Lalumière[2,4]

[1] HOPE program, San Diego, CA
[2] The Royal's Institute of Mental Health Research, Ottawa, ON
[3] Department of Psychology, University of Saskatchewan, Saskatoon, SK
[4] School of Psychology, University of Ottawa, Ottawa, ON

We examined the prevalence of hypersexuality in two combined Canadian adult community samples totalling 1,857 respondents (female $n = 960$, male $n = 835$, other $n = 60$, missing $n = 2$). Participants were recruited from social media to complete an online sexual behaviour survey that included two measures of compulsive sexual behaviour disorder— the Sexual Compulsivity Scale (SCS) and Hypersexual Behaviour Inventory (HBI)—as well as sexual behaviour and interest items. Respondents also reported their total sexual outlets (TSO)—defined by number of orgasms experienced weekly—as a third potential indicator of hypersexuality. Canadian men and women reported multiple sexual outlets per week that tended to be higher than previous reports. Men tended to report a larger number and higher frequency of various sexual behaviour than women, including higher rates of compulsive sexual behaviour disorder, which varied depending on the measure employed. Implications for establishing sexuality norms and conceptualizing hypersexuality and compulsive sexual behaviour disorder are discussed.

KEYWORDS: Compulsive sexual behaviour disorder, hypersexual behaviour inventory, hypersexuality, total sexual outlet, sexual compulsivity scale

Hypersexuality has been an elusive concep
tionalize (Kingston, 2018a, 2018b; Montgo
In the latest version of the American Psy
(2013) psychiatric nosology, hypersexua
"stronger than usual urge to have sexual act
been reported as a symptom underlying
as neurocognitive or paraphilic disorders (K
Mendez & Shapira, 2013). Some research
separate diagnostic disorder that encomp
hypersexuality along with other features,
over sexual behaviour, the use of sex in
mood, and the continuation of sexual beha
consequences. Various terms have been us
troversial construct. In this study, we exam
frequency of features considered fundam
of non-paraphilic hypersexuality in a
sample.

Kingston, D. A., Olver, M. E., Levaque, E., Sawatsky, M., Seto, M., & Lalumière, M. (2020). Establishing Canadian Metrics for Self-report Measures Used to Assess Hypersexuality. Canadian Journal of Human Sexuality

CORRESPONDENCE concerning this article should be addressed to Drew A. Kingston, HOPE program, 208-995 Gateway Center Way, San Diego, CA 92102, USA. E-mail: dkingston@hopeprogam.biz
*Drew A. Kingston and Mark E. Olver share joint lead authorship

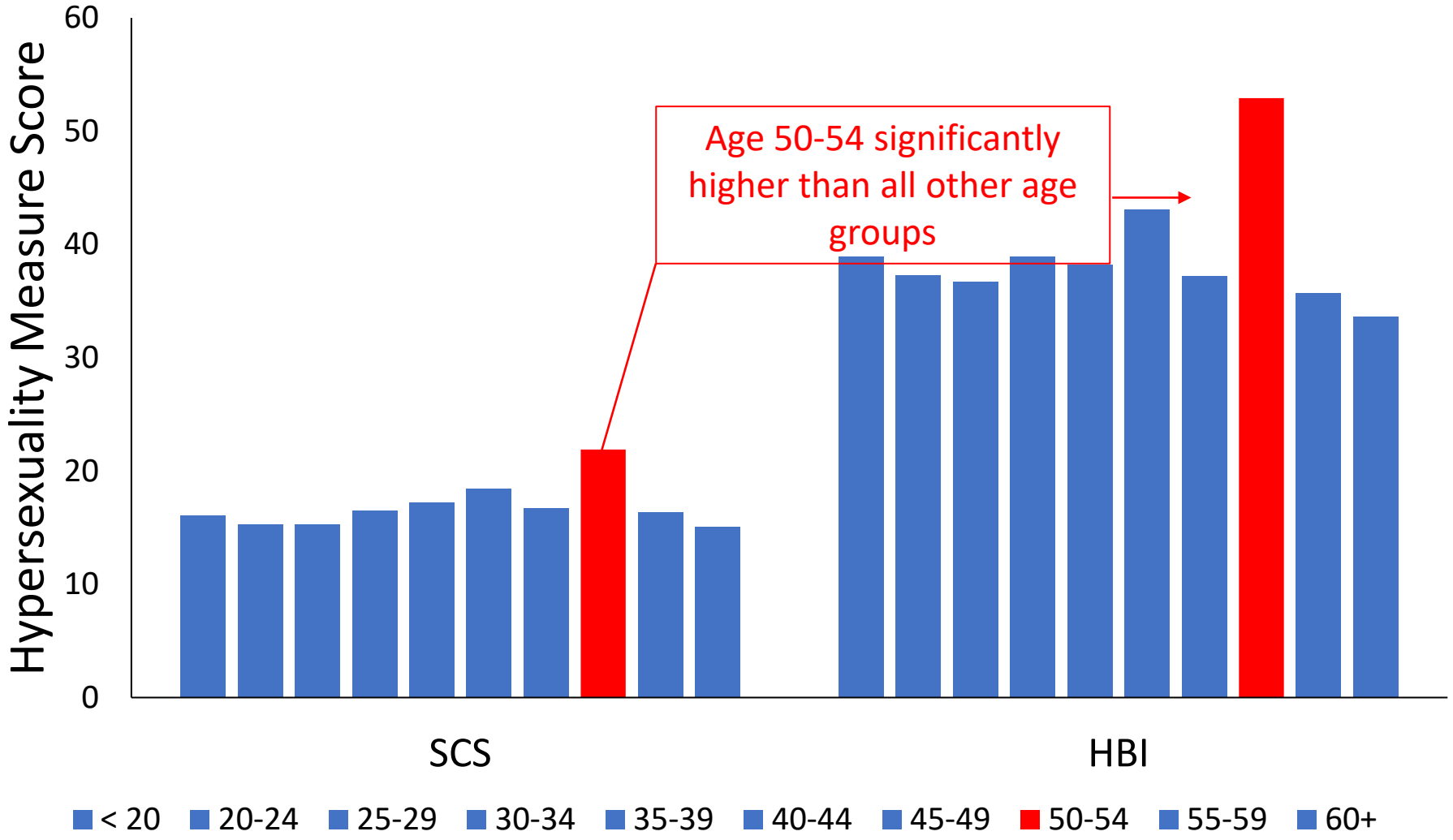
Canadian Sex Statistics

Sexual history variable	Total sample		Male	Female	
	Mean (SD) or %	Range	Mean (SD) or %		$t/\chi 2$
Masturbation (previous month)	14.9 (14.2)	0-60	21.7 (14.8)	7.2 (8.5)	17.51***
Masturbation (typical week)	4.0 (4.0)	0-30	5.7 (4.3)	2.0 (2.4)	15.75***
Sexual contact monthly (previous year)	11.7 (14.7)	0-60	10.8 (13.6)	12.7 (15.7)	-1.85
Sexual contact (previous month)	6.1 (7.9)	0-60	6.2 (7.9)	6.0 (7.9)	0.28
Sexual partners (lifetime)	13.3 (32.1)	1-500	15.5 (39.3)	11.2 (23.6)	1.82
Sexual intercourse (previous month)	5.9 (7.7)	0-60	5.9 (7.7)	6.1 (7.7)	-0.38
Sexual intercourse (previous week)	1.4 (1.9)	0-12	1.5 (2.0)	1.3 (1.9)	0.83
Total sexual outlet (TSO; week)	6.2 (5.9)	0-50	7.2 (6.5)	5.4 (5.4)	6.45
Extramarital affair (ever)	27.6	-	31.7	23.1	5.75*
Phone sex (previous year)	7.2	-	6.0	8.5	1.92
Cybersex (previous year)	17.1	-	21.4	12.6	11.31***
Strip clubs (previous year)	21.9	-	25.1	18.3	5.38*
Pay for sex (ever)	6.9	-	12.8	0.5	48.48***
Diagnosed with STI (ever)	10.6	-	8.7	13.2	5.05*

Canadian Sex Statistics

Sexual history variable	Total sample		Male	Female	
	Mean (SD) or %	Range	Mean (SD) or %		t/χ2
Masturbation (previous month)	14.9 (14.2)	0-60	21.7 (14.8)	7.2 (8.5)	17.51***
Masturbation (typical week)	4.0 (4.0)	0-30	5.7 (4.3)	2.0 (2.4)	15.75***
Sexual contact monthly (previous year)	11.7 (14.7)	0-60	10.8 (13.6)	12.7 (15.7)	-1.85
Sexual contact (previous month)	6.1 (7.9)	0-60	6.2 (7.9)	6.0 (7.9)	0.28
Sexual partners (lifetime)	13.3 (32.1)	1-500	15.5 (39.3)	11.2 (23.6)	1.82
Sexual intercourse (previous month)	5.9 (7.7)	0-60	5.9 (7.7)	6.1 (7.7)	-0.38
Sexual intercourse (previous week)	1.4 (1.9)	0-12	1.5 (2.0)	1.3 (1.9)	0.83
Total sexual outlet (TSO; week)	6.2 (5.9)	0-50	7.2 (6.5)	5.4 (5.4)	6.45***
Extramarital affair (ever)	27.6	-	31.7	23.1	5.75*
Phone sex (previous year)	7.2	-	6.0	8.5	1.92
Cybersex (previous year)	17.1	-	21.4	12.6	11.31***
Strip clubs (previous year)	21.9	-	25.1	18.3	5.38*
Pay for sex (ever)	6.9	-	12.8	0.5	48.48***
Diagnosed with STI (ever)	10.6	-	8.7	13.2	5.05*

Hypersexuality Measure Score as a Function of Age at Assessment



SCS Percentile Ranks

Men				Women			
Score	Below	Freq	Percentile	Score	Below	Freq	Percentile
10	0	5.7	2.8	10	0	16.4	8.2
11	5.7	10.0	10.7	11	16.4	18.2	25.5
12	15.7	8.7	20.0	12	34.6	11.2	40.2
13	24.4	8.9	28.8	13	45.8	9.4	50.5
14	33.3	8.7	37.6	14	55.2	9.1	59.7
15	42.0	6.5	45.2	15	64.3	6.0	67.3
16	48.5	8.2	52.6	16	70.2	5.6	73.0
17	56.7	6.7	60.0	17	75.8	4.3	77.9
18	63.4	4.3	65.5	18	80.1	3.6	81.9
19	67.7	4.2	69.8	19	83.7	1.7	84.5
20	71.8	4.2	73.9	20	85.4	2.4	86.6
21	76.0	3.3	77.6	21	87.8	1.7	88.6
22	79.3	1.8	80.2	22	89.6	1.1	90.1
23	81.1	2.5	82.3	23	90.6	1.6	91.4
24	83.6	1.9	84.5	24	92.2	1.5	92.9
25-29	85.6	1.8	86.5-91.9	25-29	93.7	1.0	94.2-97.3
30-34	92.4	1.2	93.0-96.2	30-34	97.7	0.4	97.9-99.4
35-40	96.7	1.0	97.2-99.6	35-40	99.5	0.1	99.5-99.9
Mean	**17.45**			**Mean**	**14.60**		
SD	**6.63**			**SD**	**5.12**		

HBI Percentile Ranks

Male				Female			
Score	Below	Freq	Percentile	Score	Below	Freq	Percentile
19-24	0	11.2	1.2 - 10.1	19-24	0	18.7	1.8 - 17.1
25-29	11.1	12.9	12.4 - 22.4	25-29	18.7	20.0	20.0 - 36.4
30-34	23.9	16.3	25.4 - 38.2	30-34	38.7	17.1	41.1 - 54.3
35-39	40.2	15.3	41.9 - 53.9	35-39	55.8	13.0	57.2 - 67.9
40-44	55.4	12.5	56.3 - 66.8	40-44	68.9	9.9	69.9 - 77.8
45-49	67.9	9.7	69.2 - 76.8	45-49	78.7	7.2	79.4 - 85.3
50-54	77.5	5.9	77.8 - 82.7	50-54	86.0	5.4	87.0 - 91.0
55-59	83.4	5.0	83.9 - 88.2	55-59	91.4	3.5	91.7 - 94.4
60-64	88.3	2.7	88.6 - 90.9	60-64	94.9	2.0	95.2 - 96.8
65-69	91.0	2.2	91.3 - 93.1	65-69	96.9	1.1	96.9 - 97.8
70-74	93.2	1.8	93.5 - 94.9	70-74	98.1	0.5	98.1 - 98.4
75-79	95.0	2.2	95.3 - 97.1	75-79	98.5	0.8	98.5 - 99.2
80-84	97.2	0.6	97.3 - 98.0	80-84	99.3	0.1	99.3 - 99.4
85-89	98.3	0.8	98.3 - 99.0	85-89	99.4	0.2	99.4 - 99.5
90-95	99.1	0.9	99.1 - 99.9	90-95	99.7	0.3	99.7 - 99.9
Mean	40.81			Mean	35.59		
SD	15.43			SD	12.83		

TSO Percentile Rank

Male				Female			
Score	Below	Freq	Percentile	Score	Below	Freq	Percentile
0	0	0.7	0.3	0	0	5.3	2.6
1	0.7	2.2	1.8	1	5.3	10.9	10.8
2	2.9	2.7	4.2	2	16.2	7.3	19.8
3	5.6	6.6	8.9	3	23.5	9.0	28.0
4	12.2	10.4	17.4	4	32.5	10.4	37.7
5	22.6	12.7	28.9	5	42.8	9.7	47.6
6	35.3	18.6	44.6	6	52.5	17.3	61.1
7	53.8	17.3	62.4	7	69.9	14.8	77.3
8	71.2	16.4	79.4	8	84.7	11.1	90.2
9	87.5	1.7	88.3	9	95.8	0.2	95.9
10	89.3	4.2	91.4	10	96.0	1.1	96.5
11	93.4	0.2	93.5	11	97.0	01	97.1
12	93.7	0.6	94.0	12	97.1	0.1	97.2
13	94.3	0.2	94.4	13	97.3	0.1	97.4
14	94.5	1.5	95.2	14	97.4	0.2	97.5
15	96.0	0.2	96.1	15	97.6	0.2	97.7
16-25	96.2-97.8	1.6	96.2-97.9	16-25	97.8-98.3	0.5	97.9-99.4
26-50	97.9-98.7	2.2	97.9-99.3	26-50	98.3-99.3	1.6	99.5-99.9
Mean (SD)	7.21 (6.45)			Mean (SD)	5.4(5.41)		
n	819			n	946		

Assessment and Diagnosis

Assessment

- Screening
  - PATHOS (Carnes et al., 2012)
    - P – Do you find yourself **preoccupied** with sex
    - A – Do you hide some of your sexual behaviors from others **(ashamed)**
    - T – Have you ever sought **treatment**
    - H – Has anyone been **hurt** emotionally by your sexual behavior
    - O – Do you feel **out of control** re: sexual activity
    - S – Do you feel depressed or **sad** after sexual activity
  - Compulsive Sexual Behavior Disorder Diagnostic Inventory

Screening

Appendix A: CSBD-DI with Additional Coping Items

Instructions: Below are statements that describe various thoughts, feelings, and behaviors. As you answer each question, select a response that best describes what is true for you. Only select one response for each statement and please be sure to answer every question. For this questionnaire, sex is defined as any activity or behavior that stimulates or arouses a person with the intent to produce an orgasm or sexual pleasure. (e.g., self-masturbation or solo-sex, using pornography, intercourse with a partner, oral sex, anal sex, etc…) *Sexual behaviors may or may not involve a partner*.

1 -	I have spent too much time focused on sexual fantasies, sexual urges, *and* sexual behaviors to the extent I neglect responsibilities (e.g. work, education, etc…), my health, or personal relationships.		
	❑ This has been true for at least 6 months during the last 12 months	❑This has been true in my lifetime but not during the last 12 months	❑This has never been true of me.
2 -	I have made numerous unsuccessful attempts to stop, reduce or control the frequency of my sexual fantasies, urges, *and* behaviors?		
	❑This has been true for at least 6 months during the last 12 months	❑This has been true in my lifetime but not during the last 12 months	❑This has never been true of me.
3 -	I often engage in sexual behavior despite the risk of *physical harm* (e.g. sexually transmitted infection, unintended pregnancy, injury, or illness, etc…).		
	❑This has been true for at least 6 months during the last 12 months	❑This has been true in my lifetime but not during the last 12 months	❑This has never been true of me.
4	I often engage in sexual behavior despite the risk of *emotional harm* to myself or others (such as hurting the		

Assessment

- Comprehensive clinical/psychiatric interview
  - Diagnostic relevant questions including:
    - Problematic sexuality and sexual drive (e.g., TSO) dimensions
- Medical testing
  - Rule out medical or other conditions/causes
- Multi-method/modal assessments
  - Clinician administered and self-report
  - Emphasis placed on empirically derived cut-off’s

Journal of Sex & Marital Therapy, 36:227–260, 2010

ISSN: 0092-623X print / 1521-0715 online
DOI: 10.1080/00926231003719673

Routledge
Taylor & Francis Group

Measuring Sexual Addiction and Compulsivity: A Critical Review of Instruments

JOSHUA N. HOOK
Department of Psychology, Virginia Commonwealth University, Richmond, Virginia, USA
JAN P. HOOK
The Arlington Center, Arlington Heights, Illinois, USA
DON E. DAVIS and EVERETT L. WORTHINGTON JR.
Department of Psychology, Virginia Commonwealth University, Richmond, Virginia, USA
J. KIM PENBERTHY
Department of Psychiatry and Neurobehavioral Sciences, University of Virginia, Charlottesville, Virginia, USA

Research has proliferated on sexual addiction in recent years, and this has led to an increase in th sure this construct. The authors re been created to assess sexual addi ing scales, self-report checklists, ar suring symptoms of sexual addicti scales measuring consequences as For each instrument, the authors d basis, and samples studied. They al reliability and validity of each ins widely in their psychometric prope recently, and others have only been For each group of instruments, the a for researchers and clinicians.

Hook, J. N., et. al. (2010). Measuring Sexual Addiction and Compulsivity: A Critical Review of Instruments. Journal of Sex and Marital Therapy, 36, 227-260.

Sexual addiction (Carnes, 1983), *compulsive sexual behavior* (Coleman, 1991), *sexual compulsivity* (Kalichman & Rompa, 1995), and *sexual impulsivity* (Barth & Kinder, 1987) are all terms that describe a psychological disorder that is defined by a person's inability to control his or her sexual behavior.

Montgomery-Graham (2017, p. 158)

Table 4. Rankings of psychometric properties of HD measurements using the criteria of Hunsley and Mash[77]

	Construct validity	Content validity	Norms	Validity generalization	Internal consistency	Test-retest reliability	Inter-rater reliability*
HDSI	A	A	A	A	G to E	A	E
SCS	G	G	A	G	G	G	—
HBI	G	G	A	A	E	A	—
CSBI	A	A	A	A	G	A	—
SAST	G	A	A	>A	E	U	—
SAST-R	A	A	A	U	>A to A	U	—

A = adequate; CSBI = Compulsive Sexual Behavior Inventory; E = excellent; G = good; HBI = Hypersexual Behavior Inventory; HD = hypersexual disorder; HDSI = Hypersexual Disorder Screening Inventory; SAST = Sexual Addiction Screening Test; SAST-R = Sexual Addiction Screening Test—Revised; SCS = Sexual Compulsivity Scale; U = data not yet available.

*Note that inter-rater reliability is reported only for the HDSI, which can be administered by a clinician, making inter-rater reliability a useful psychometric property to research, whereas the remaining HD scales are self-report measurements.

Hypersexual Disorder Screening Inventory

Instructions: Please respond the following statements regarding your sexual thoughts, fantasies, and behavior that have **persisted for a period of 6 continuous months or longer during the past 12 months**. For the purpose of this questionnaire, sex is defined as any activity or behavior that stimulates or arouses a person with the intent to produce an orgasm or sexual pleasure. *Sexual behaviors may or may not involve a partner*. (e.g. self-masturbation or solo-sex, using pornography, intercourse with a partner, oral sex, anal sex, etc…). Only circle one number per statement and please be sure to answer *every* question.

			Never True	Rarely True	Sometimes True	Often True	Very Often True	Almost Always True
A1	1.	I spend too much time engaging in sexual fantasies and urges.	0	1	2	3	4	5
	2.	I spend too much time planning for, and engaging in sexual behavior.	0	1	2	3	4	5
A2	3.	I have used sexual fantasies, urges, and behaviors when I have experienced difficult or unpleasant moods or feelings (e.g., such as depression, sadness, anxiety, boredom, restlessness, shame, or irritability).	0	1	2	3	4	5
A3	4.	I have used sexual fantasies, urges, and behaviors as a way to avoid, cope, or deal with stressful experiences or difficult responsibilities in my life.	0	1	2	3	4	5
A4	5.	I have been *unsuccessful* in my efforts to reduce or control the frequency of sexual fantasies, urges, and behaviors in my life.	0	1	2	3	4	5
A5	6.	I have continued to engage in sexual behavior despite the risk of *physical harm* (e.g. sexually transmitted infection, unintended pregnancy, injury, or illness) to myself or others such as a romantic partner, a family member, or close friends.	0	1	2	3	4	5
	7.	I have continued to engage in sexual behavior while disregarding the risk of *emotional harm* to myself or others such as a romantic partner, a family member, or close friends.	0	1	2	3	4	5
B1	8.	Frequent and intense sexual fantasies, urges, and behavior have caused personal distress in my life (e.g. feelings of sadness, depression, shame, guilt, self-hatred, regret, worry, or hopelessness).	0	1	2	3	4	5
B2	9.	Frequent and intense sexual fantasies, urges, and behavior have caused significant problems in my personal relationships with others, social situations, work, or other important aspects of my life.	0	1	2	3	4	5
C1	10.	Frequent and intense sexual fantasies, urges, and behaviors have occurred in my life independently, separately, or apart from any use of drugs, alcohol, or prescription medications.	0	1	2	3	4	5

Hypersexual Disorder Screening Inventory is based on DSM-5 proposed classification criteria for Hypersexual Disorder by Dr. Marty Kafka

Sexual Compulsivity Scale – Revised

A number of statements that some people have used to describe themselves are given below. Read each statement and then circle the number to show how well you believe the statement describes you.

		Not at all like me	Slightly like me	Mainly like me	Very much like me
1.	My sexual appetite has gotten in the way of my relationships.	1	2	3	4
2.	My sexual thoughts and behaviors are causing problems in my life.	1	2	3	4
3.	My desires to have sex have disrupted my daily life.	1	2	3	4
4.	I sometimes fail to meet my commitments and responsibilities because of my sexual behaviors.	1	2	3	4
5.	I sometimes get so horny I could lose control.	1	2	3	4
6.	I find myself thinking about sex while at work.	1	2	3	4
7.	I feel that sexual thoughts and feelings are stronger than I am.	1	2	3	4
8.	I have to struggle to control my sexual thoughts and behavior.	1	2	3	4
9.	I think about sex more than I would like to.	1	2	3	4
10.	It has been difficult for me to find sex partners who desire having sex as much as I want to.	1	2	3	4

(HBI-19)

Date:_____

ID #: _____

Below are a number of statements that describe various thoughts, feelings, and behaviors. As you answer each question, circle the number on the right that best describes you. Only circle one number per statement and please be sure to answer every question.

For the purpose of this questionnaire, sex is defined as any activity or behavior that stimulates or arouses a person with the intent to produce an orgasm or sexual pleasure. (e.g. self-masturbation or solo-sex, using pornography, intercourse with a partner, oral sex, anal sex, etc…) *Sexual behaviors may or may not involve a partner*.

		Never	Rarely	Sometimes	Often	Very Often
1.	I use sex to forget about the worries of daily life.	1	2	3	4	5
2.	Even though I promised myself I would not repeat a sexual behavior, I find myself returning to it over and over again.	1	2	3	4	5
3.	Doing something sexual helps me feel less lonely.	1	2	3	4	5
4.	I engage in sexual activities that I know I will later regret.	1	2	3	4	5
5.	I sacrifice things I really want in life in order to be sexual.	1	2	3	4	5
6.	I turn to sexual activities when I experience unpleasant feelings (e.g. frustration, sadness, anger).	1	2	3	4	5
7.	My attempts to change my sexual behavior fail.	1	2	3	4	5
8.	When I feel restless, I turn to sex in order to soothe myself.	1	2	3	4	5
9.	My sexual thoughts and fantasies distract me from accomplishing important tasks.	1	2	3	4	5
10.	I do things sexually that are against my values and beliefs.	1	2	3	4	5
11.	Even though my sexual behavior is irresponsible or reckless, I find it difficult to stop.	1	2	3	4	5
12.	I feel like my sexual behavior is taking me in a direction I don't want to go.	1	2	3	4	5
13.	Doing something sexual helps me cope with stress.	1	2	3	4	5
14.	My sexual behavior controls my life.	1	2	3	4	5
15.	My sexual cravings and desires feel stronger than my self-discipline.	1	2	3	4	5
16.	Sex provides a way for me to deal with emotional pain I feel.	1	2	3	4	5
17.	Sexually, I behave in ways I think are wrong.	1	2	3	4	5
18.	I use sex as a way to try and help myself deal with my problems.	1	2	3	4	5
19.	My sexual activities interfere with aspects of my life such as work or school.	1	2	3	4	5

Rory C. Reid, Ph.D., Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles
Sheila Garos, Ph.D., Psychology Department, Texas Tech University
Bruce N. Carpenter, Ph.D., Department of Psychology, Brigham Young University

Reid, R. C., Garos, S. & Carpenter, B. N. (2011). Reliability, validity, and psychometric development of the Hypersexual Behavior Inventory in an outpatient sample of men. *Journal of Sexual Addiction & Compulsivity, 18*(1), 30-51.

COPING: 1.3.6.8.13.16.18 CONSEQUENCES: 5.9.14.19 CONTROL: 2.4.7.10.11.12.15.17

Reid et al., 2011

Thank you!

dkingston@hopeprogram.biz

https://www.hopeprogram.biz/

liam@rockwoodpsyc.com