Psychiatry has a long tradition of believing that too much sex is a bad thing. The classical literature provides detailed accounts of men and women who demonstrated apparently pathological sexual appetites. Since Freud, psychoanalytic authors have held that masturbation is unhealthy, and psychodynamically oriented thinkers have written on Don Juanism and nymphomania.

On the other hand, the cultural climate of the 1960s and the work of sexologists since Kinsey, has helped give sex a much sexier image. Many clinicians continue to spend a great deal of time convincing patients with sexual hypofunction that sex is natural, healthy, and pleasurable. Mastery of masturbation is now seen as an important first lesson for the patient or couple undergoing sex therapy.

Perhaps the pendulum has swung too far. Quite clearly, there is a substantially large group of patients where excessive sexual activity is accompanied by "clinically significant distress or marked impairment in social, occupational, or other important areas of functioning." Although rigorous epidemiological and pharmacoeconomic data remains to be collected in this area, for the clinician familiar with these unfortunate patients, the high prevalence and morbidity of excessive sexual behavior is inarguable. Nevertheless, in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), this category of patients is not given a specific label.

Indeed, the question of what to call this disorder is one that is fraught with difficulty, and the lack of consensus has perhaps further contributed to its relative neglect. The *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (DSM-III) referred to "nonparaphilic sexual addictions," and others have also supported the use of the term sexual addiction. Many, however, have argued that this term stretches a metaphor too far. Terms such as sexual compulsivity or sexual impulsivity again seem to have both pros and cons.

In this issue, contributors summarize some of the available knowledge on patients with excessive nonparaphilic sexual fantasies, urges, or behavior. Black describes the epidemiology and clinical features; Stein and colleagues review its putative neurobiology; Kafka, a pioneer in the psychopharmacology of these symptoms, reviews various pharmacologic approaches. Finally, Stein and Black suggest the term hypersexual disorder, and put forward relevant diagnostic criteria. We hope that this issue will increase clinicians’ awareness of this entity, and also encourage sorely needed rigorous research.

**REFERENCES**


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Dr. Stein is Director of the MRC Research Unit on Anxiety Disorders in the Department of Psychiatry at the University of Stellenbosch in Cape Town, South Africa, and is also in the Department of Psychiatry at the University of Florida in Gainesville. Dr. Black is professor in the Department of Psychiatry at the University of Iowa College of Medicine in Iowa City.
Published study results (n=29):

• ADDERALL produced a statistically significant, dose-related increase in objective measures of behavior (number of age-appropriate math problems attempted and math problems correct) as compared to placebo.

• The duration of action of ADDERALL effects on behavior were dose dependent.

• No unusual or serious side effects were noted in this study.

ADDERALL usage data (n=611) indicate that over 90% of patients can be maintained on a dosage frequency of 1-2 times per day.

ADDERALL is generally well-tolerated—adverse reactions have seldom been reported (most frequently reported adverse reactions include anorexia, insomnia, stomach pain, headache, irritability, and weight loss).

As with most psychostimulants indicated for ADHD, the possibility of growth suppression and the potential for precipitating motor tics and Tourette's syndrome exists with ADDERALL treatment and, in rare cases, exacerbations of psychosis have been reported. Since amphetamines may have a high potential for abuse, ADDERALL should only be prescribed as part of an overall multimodal treatment program for ADHD with close physician supervision.

* Thirty-four patients receiving greater than 40 mg per day were excluded from this analysis.

Please see references and brief summary of prescribing information on adjacent page.

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MHFA: A DEFINITIVE POTENTIAL FOR ABUSE. ADMINISTRATION OF AMPHETAMINES FOR PROLONGED PERIODS OF TIME MAY LEAD TO DRUG DEPENDENCE AND MUST BE AVOIDED. PARTICULAR ATTENTION SHOULD BE PAID TO THE POSSIBILITIES OF SUBJECTS OBTAINING AMPHETAMINES FOR NON-THERAPEUTIC USE OR DISTRIBUTION TO OTHERS, AND THE DRUGS SHOULD BE PRESCRIBED OR DISPENSED SPARINGLY.

INDICATIONS: Attention Deficit Disorder with Hyperactivity: ADDERALL is indicated as an integral part of a total treatment program which typically includes other remedial measures (psychological, educational, social) for a stabilizing effect in children with behavioral syndrome characterized by the following group of developmentally inappropriate symptoms such as hyperactivity, inattention, impulsivity, and irritability, and impulsivity. The diagnosis of this syndrome should not be made with finality when these symptoms are only of comparatively recent origin. Nonlocalizing (soft neurological signs) are often absent, or if present, are not consistent in type or degree with the severity of the symptomatology. The diagnosis may be excluded only by an appropriate degree of normality in the child's overall level of functioning. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result). WARNINGS: Clinical experience suggests that in pancytopenic patients, amphetamines should not be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Information for Patients: Amphetamines may impair the ability of the patient to engage in activities requiring mental alertness and physical coordination. Severe social disability have been reported with the use of amphetamine. Pregnancy - Teratogenic Effects: Prenatal drug exposure may determine whether chronic administration of amphetamine may be associated with growth retardation, deceleration of intrauterine growth rate, and other changes associated with intrauterine growth retardation. Amphetamines are excreted in human milk. Mothers taking amphetamines should be advised to refrain from nursing. PRECAUTIONS: General: Caution is to be exercised in prescribing amphetamines to patients with a history of drug addiction or psychoneurosis. Patients with a history of drug addiction or psychoneurosis. In cases of propoxyphene overdosage, amphetamine CNS stimulation is possible. There have been isolated reports of overdosage with amphetamines to levels as low as 2 mg, they are rare with doses of less than 15 mg; 30 mg can produce severe reactions, yet doses of 400 to 4000 mg of amphetamine produce only drowsiness. Anorexia and weight loss are possible. Manifestations of acute overdosage with amphetamines include hyperactivity, excitement, restlessness, talkativeness, irritability, elation, insomnia, euphoria, dyskinesia, dysphoria, tremor, headache, exacerbation of motor and phonic tics and Tourette's syndrome. There is no specific antidote for amphetamine poisoning. Symptomatology of amphetamine poisoning includes hallucinations, panic states, hyperpyrexia and rhabdomyolysis. Fatigue and depression are rare. This slowing potentiates amphetamines, increasing their effect on the release of amphetamine in the brain; cardiovascular effects can be potentiated. Antihypertensives - Amphetamines may delay intestinal absorption of antihypertensive agents lower blood levels and efficacy of amphetamines. Antidepressants, tricyclic - Possibly other tricyclics cause striking and sustained increases in the concentration of d-amphetamine. Lithium carbonate - Dextroamphetamine sulfate may be used. The suggested initial dose of dextroamphetamine sulfate may be used. Dextroamphetamine sulfate is a Schedule II controlled substance. Therefore, clinical evaluation for tics and Tourette's syndrome in children and their families should precede use of stimulant medications. Drug treatment is not indicated in all cases of Attention Deficit Disorder with Hyperactivity and should be considered only in cases in which the complete history and physical examination, and the laboratory tests indicate the need for such treatment. Amphetamines should depend on the physician's assessment of the child's condition and severity of the symptoms and their appropriateness for higher age. Amphetamines are not recommended for use in children under 3 years of age. Amphetamines are not recommended for use in children under 3 years of age. Amphetamines are excreted in human milk. Mothers taking amphetamines should be advised to refrain from nursing. ADDERALL I.Swanson J.Wigal S, Greenhill L, et al. Analog classroom assessment of Adderall in children with ADHD. Am Acad Child Adolesc Psychiatry. May 1998;37(5):519-526. 2. Data on file, Shire Richwood Inc. Analysis of open-label data collected from March 1995 through February 1996. 3. ADDERALL

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