Existential Issues in Sexual Medicine: The Relation Between Death Anxiety and Hypersexuality

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ABSTRACT

Introduction: Current sex therapy and sexual medicine protocols often ignore the existential dilemmas associated with sexual dysfunction and other problematic sexual problems. This oversight is especially apparent when assessing and treating the controversial phenomenon of hypersexuality, or "sexual addiction." A deeper understanding of the existential concept of death anxiety could offer an alternative treatment paradigm that might lead to a more effective treatment outcome.

Aim: To explore the relation between the existential phenomenon of death anxiety and hypersexuality (ie, sexual addiction) and present an evaluation and treatment paradigm that is rooted in existential psychotherapy, a form of psychotherapy that is a deeply life-affirming and dynamic approach to therapy that focuses on concerns rooted in the individual's existence.

Methods: A review of the literature focusing on the topics of hypersexuality, death anxiety, and existential psychotherapy was undertaken and a treatment paradigm is offered.

Main Outcome Measures: Current treatment protocols for hypersexuality and sexual addiction were reviewed, as were current concepts in existential therapy. These were integrated into an assessment and treatment paradigm.

Results: Although sexual medicine and traditional sex therapy techniques can often alleviate sexual suffering, there are times when a more in-depth psychotherapy is needed to get to the root cause and ultimate assuagement of the presenting sexual symptoms. Existential psychotherapy is one such form of treatment that allows clinicians to probe the subterranean depths of the human psyche and make meaning of one's sexual behavior and its vagaries.

Conclusion: Although certainly not all cases of hypersexuality are precipitated by a confrontation with mortality and death, there are cases in which sex is imbued with meaning as an antidote to the fear of death. Existential therapy is a form of treatment that could be particularly effective in many of these cases. **Watter DN. Existential Issues in Sexual Medicine: The Relation Between Death Anxiety and Hypersexuality. Sex Med Rev 2018;6:3–10.**

Key Words: Existential Psychotherapy; Death Anxiety; Hypersexuality; Sexual Addiction; Sexual Medicine; Sex Therapy

INTRODUCTION

Existential concerns have rarely been addressed in the sex therapy and sexual medicine literature,[1,2] although early existentially oriented therapists have commented on the existential dynamics associated with sexual dysfunctions.[3,4] The early groundbreaking days of sex therapy, pioneered by Masters and Johnson,[5] focused mostly on a combination of corrective sex education and behavioral interventions to alleviate the symptoms of sexual dysfunction. Since that time, sex therapy has evolved into a combination of psychological practices similar to cognitive-behavioral therapy and, most recently, an increasing reliance on medical interventions.[6] As a result of the emergence of medicine as the de facto leader in the sex therapy arena, many clinicians have feared the loss of the psychological dynamics integral to a complete understanding of sexual function and dysfunction and have advocated for a more integrated biopsychosocial model for assessing and treating sexual difficulties.[7–9] Although each of these advances has had a significant impact on the evolution of, and growth in, our understanding of sexuality and the treatment of sexual difficulties, there have been voiced concerns that the deeper psychological underpinnings of much sexual distress are being subordinated to

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the lure of symptom-focused treatments as opposed to those focused on the identification and amelioration of the more profound etiologic psychological conflicts that activated such symptoms to begin with.

Although the alleviation of problematic sexual symptomology is certainly appreciated and desired by most patients, many sex therapy and sexual medicine clinicians will tell of countless cases in which the dysfunction has resolved, but the patients continue to report disappointment that their sexual and relational lives have not become more fulfilling and satisfying. Existential psychotherapy posits that this is likely the result of the treatment having neglected to address the often-concealed meaning(s) that sexuality and sexual functioning might hold for this patient(s). Existential psychotherapy is a psychotherapy that focuses on the *meaning of our existence* and as such the meaning that sexuality and our relationship with ourselves and others evoke. Regrettably, the existential texts and the sex therapy and sexual medicine texts rarely reference each other. Barker[2] observed that even within the existential therapy community, clinicians often see the understanding, exploration, and treatment of sexual problems as something apart from other concerns of human suffering rather than as another avenue of gaining entry into the patient's psyche. The aim of this article was to explore and delineate the existential dilemmas that often manifest through disruptions in our sexual lives. Although a complete elucidation of the myriad presentations of existential concerns that manifest as sexual difficulties is beyond the scope of this article, one particular existential dilemma, death anxiety, and its role in the construction of the controversial phenomenon of hypersexuality or "sexual addiction" are scrutinized.

EXISTENTIAL PSYCHOTHERAPY AND DEATH ANXIETY

Existential psychotherapy is a deeply life-affirming and dynamic approach to therapy that focuses on concerns rooted in the individual's existence.[3] That is, the works of eminent philosophers heavily influence the existential approach to therapy and inform the treatment in assisting the individual to navigate the vagaries inherent in human existence. Problems are seen as a puzzle that the patient and clinician work together to solve.

Barker[2] stated that the existential approach to therapy does not concern itself with diagnosis per se. Although diagnosis is critical in those psychiatric conditions with a strong biological influence (ie, schizophrenia, bipolar disorder, etc), diagnosis could be counterproductive in psychotherapy of less psychiatrically impaired patients.[10] This would include the bulk of patients in sex therapy. Barker[2] and Yalom[9] asserted that in many cases diagnosis can interfere with treatment because it can diminish or limit the therapist's ability to view patients as "people" as opposed to "diseases." Yalom[10] took this a step further in essentially advocating a new therapy for each patient. He lamented that standardization of treatment might render therapy less effective by failing to appreciate the uniqueness of each individual and the psychological meaning given to that individual's sexual functioning. Barker[2] emphasized that existential psychotherapy follows an approach that is somewhat antithetical to current psychiatry. She stressed that diagnosis and treatment based on symptoms miss the essential existential meaning of these symptoms and thus dehumanize the individual. Correspondingly, Kleinplatz[11] and Spinelli[12] stated that a focus on simply relieving symptoms is likely to lead to only temporary symptom alleviation because crucial psychodynamic factors that are likely to be represented in the expression of the sexual dysfunction will remain unaddressed.

According to Yalom,[3] there are 4 primary existential concerns that plague human existence: freedom, isolation, meaninglessness, and death (the focus of this article). Uncertainties related to any of these can result in sexual difficulties, although a comprehensive discussion of each is beyond the scope of this article. Death anxiety, or more precisely death terror, has been implicated in disruptions in the sexual functioning of many. Indeed, much of Western society values the sexuality of youth and attempts to discount, perhaps out of fear, the sexuality of aging and maturity. Congruently, given the reality of death in the lives of all humans, the fear of death is likely to be universal. Callahan and Gaylin[13] posited that all humans struggle with the dilemma of rebellion vs acceptance of death. They asserted that in the current climate of medical intervention, rebellion is the dominant force. This has culminated in some medical visionaries making the "elimination of death," or its indefinite postponement, their mission. Interestingly, some have even suggested that pharmaceutical interventions, such as sildenafil citrate, might actually represent a disservice for aging men because such interventions seek to promise the restoration of the sexuality of youth instead of supporting and nurturing the acceptance of natural aging and the reality that sexual functioning in the mature years might be different but still highly enjoyable. Watter[6] challenged sexual medicine specialists to look beyond the rudimentary observation that men will be happy if their aging penises function like the penis of their youth and consider the question of whether we are fostering unrealistic expectations relative to the idea that we can, in essence, "cheat" death. That is, is our use of sexual pharmaceuticals tantamount to encouraging the notion that our bodies need not age, that sexual functioning need not change, and that human life need not eventually end? Clearly, death is seen by the masses as something to be avoided, yet it is one of the few certainties of life. Conversations about death are frightening and feel risky, so much so that even psychotherapists and physicians are often reluctant to broach this topic with their patients.

Yalom[10] stated, "Though the physicality of death destroys us, the idea of death may save us." Death awareness and death anxiety can act as a powerful catalyst for change. That change can be life enhancing or life effacing. Take, for example, the character of Ebenezer Scrooge in Charles Dickens' story *A Christmas*

Carol.[14] For those unfamiliar with *A Christmas Carol,* Ebenezer Scrooge is a miserly, bitter, isolated man who cares little for those around him. Indeed, he is seen as a blight on the society in which he lives. He contributes none of his wealth to the betterment of his community and displays little or no compassion for the suffering of those around him. Interestingly, Scrooge is no stranger to suffering and has been visited by the trauma of early death at several critical points throughout his life. Perhaps most significantly, his mother dies while giving birth to him. In his grief, Scrooge's father banishes him from the home and refuses to have any contact with him. Only Scrooge's sister, Fan, shows him any concern and compassion, but she, too, tragically dies in childbirth. Her son, Fred, tries to engage Scrooge at every opportunity, but Scrooge scorns him, much like he himself was scorned by his father. It is no wonder, then, that when Scrooge is compelled by the Ghost of Christmas Yet To Come to confront his own demise, he is greatly affected and forever changed. Faced with the awareness that he will be missed by no one, will have left no legacy of meaning, and will be nothing more than a sour memory in the minds of those in his community, Scrooge is propelled to change his life. He becomes the most generous and beloved man in town, helping those in need, and being thoughtful, charitable, and agreeable to all. "Though the physicality of death destroys, the idea of death may save us." Such is the fortunate fate of Ebenezer Scrooge. His confrontation with mortality and his deep-seeded terror of death save Scrooge from living his remaining days in isolation and meaninglessness. Many are not so fortunate, and their death terror can send their behavior spiraling out of control. Beck[15] opined that slavery to the fear of death affects every facet of the human experience, without exception. He further stated that our fear of death is often so deeply hidden and repressed that is it often difficult to detect its existence and impact.

Of course, not everyone feels terror at the prospect of the end of their existence, but for many the knowledge that one's being will ultimately end can provoke an extreme, uncharacteristic, and problematic reaction. According to Becker,[16] when the repression of the terror of death breaks down, people will often behave in ways that might seem frenetic or even psychotic. Frequently, those reactions will manifest sexually. Yalom[10,17] affirmed that concerns about death can manifest in the preoccupation with sexual thoughts and behaviors. Freud,[18] too, recognized the powerful connection between the sex drive (Eros) and the death instinct (Thanatos). For many, sex is experienced as a life force, the antithesis of death that can neutralize the terror of the end of one's existence. Such cases are considered later in this article.

HYPERSEXUALITY AND SEXUAL ADDICTION

The assessment and treatment of hypersexuality, or sexual addiction, is a controversial and fervently debated topic in current sex therapy and sexual medicine. Indeed, its very existence has been questioned.[19,20] Despite the frequent references to sexual addiction in the press, popular literature, much of the professional literature, and complaints patients bring into therapy, hypersexuality and sexual addiction were not seen as having adequate empirical support for inclusion in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.*[21]

The Chinese philosopher Confucius is said to have pronounced, "the beginning of wisdom is to call things by their proper name."[22] Inelegantly, the phenomenon of hypersexuality has been referred to by many different names: hypersexuality,[23] sexual addiction,[24] and out-of-control sexual behavior,[25] to note a few. In commenting on the lack of specificity in the assessment and diagnosis of sexual addiction, Grubbs et al[23] echoed Confucius when they pointed out the confusion that results from our inability to properly define the nature of hypersexuality.

Most patients presenting with such difficulty will use the popular "sex addiction" label to describe their situation. Although academics and clinicians passionately debate the proper diagnostic label, existential psychotherapists do not expend much time and/or effort engaged in this argument. As mentioned earlier, existential psychotherapy does not concern itself with diagnosis per se. To the existential therapist, the persons sitting in the room with us have their own story and unique set of circumstances. The polemic of diagnosis only distracts from the distinctive nuanced narrative patients bring into the consultation room. The focus on diagnosis lends itself to the misleading assumption that any and all patients presenting with this type of problematic sexual behavior should be treated using essentially the same treatment protocol. This dilemma was well summed up by Cantor et al[26]:

> Despite that the literature emphasizes that cases of hypersexuality are highly diverse with regard to clinical presentation and comorbid features, the major models for understanding and treating hypersexuality employ a 'one-size-fits-all' approach. That is, rather than identify which problematic behaviors might respond best to which interventions, existing approaches presume or assert without evidence that all cases of hypersexuality (however termed or defined) represent the same underlying problem and merit the same approach to intervention. [p. 883]

As mentioned earlier, existential therapy strives to create a new therapy for each person in an effort to recognize the individuality of the patient and the meaning the behavior might have for that patient.

RELATION BETWEEN SEX AND DEATH

To reiterate, Yalom[10,17] stated that concerns about death can manifest in the preoccupation with sexual thoughts and behaviors. For many, sex is experienced as a life force, the antithesis of death that can neutralize the terror of the end of one's existence.

He described sex as "death-defeating" for some people because death is connected with banality and ordinariness, whereas sex promises to be exciting and magical. In addition, an increase in sexual activity in those diagnosed with life-threatening illnesses is often observed, and for these people their uncharacteristically amplified sexual behavior can be understood as an attempt at repression of their overpowering death anxiety.[3] Ford et al[27] reported on a study of college students who completed measures of death anxiety and risk taking. They found that when viewed in the context of defensive behavior, an increase in willingness to engage in risky sexual behavior as a result of raising the issue of personal mortality could be conceptualized as a denial-based defensive reaction designed to ward off conscious anxiety aroused by the issue of death. This is consistent with study by Miller and Mulligan[28] who investigated the effects of mortality salience and locus of control on risk taking. They, too, found that mortality salience increased the likelihood of risk-taking behaviors in certain populations. Becker[16] alleged that in the face of danger there always lurks the basic fear of death, a fear that is complex in its presentation and manifests in many indirect ways.

Such instances of increased sexual behavior as a result of a confrontation with mortality and the terror of death have been noted by others in the psychological and literary worlds. Psychologist Gurit Birnbaum[29] wrote:

> The awareness that death is inescapable, coupled with the instinctive desire to live, can constitute an unbearable paradox. To escape this potentially paralyzing terror and to maintain psychological equanimity, some people may employ certain defense mechanisms, which are designed to remove the awareness of death from conscious thoughts by imbuing the world with meaning, order, and permanence. Often people will reach for symbols of immortality. And sex can be a big one.

Writer Stephanie Waxman[30] voiced the story of Big Tessa:

> During the week that Big Tessa faced the decision to undergo a risky (with no guarantees) bone marrow transplant to thwart the greater evil, an aggressive cancer, we took a walk in the desert on the outskirts of Palm Springs. It was early April and scarlet blooms were already popping open on the paddle cactus and the air was filled with the scent of sage. After walking in silence for a while, she stopped, and in her usual frank way, asked my advice: in the face of cancer and the transplant—and in either case and in all probability, in the face of death—what action could she take to affirm life? The answer came to me in a thunderbolt of absolute certainty and I offered it without hesitation and with great conviction: "Have lots of sex."
>
> It was no doubt naïve of me to think it possible to feel sexual when facing such a battle and such choices. But at the moment it seemed logical that the basic act of procreation was the best antidote to destructive forces.

Elie Wiesel[31] wrote that on the train ride to the Nazi death camps:

> Freed of normal constraints, some of the young let go of their inhibitions and, under cover of darkness, caressed one another, without any thought of others, alone in the world. The others pretended not to notice.

In describing the relation between sex and death, Yalom[32] noted:

> Sex, the vital life force, often counters thoughts of death. I've encountered many instances of this mechanism: the patient with a severe coronary who was so sexually driven that in an ambulance carrying him to the emergency room, he attempted to grope an ambulance attendant; or the widow who felt overcome with sexual feelings while driving to her husband's funeral; or the elderly widower, terrified by death, who became uncharacteristically sexually driven and had so many sexual affairs with women in his retirement community and created such divisiveness that the management demanded he seek psychiatric consultation. Still another elderly woman, after her twin sister had died from a stroke, become so overcome with multiple orgasms while using a vibrator that she feared she too would suffer a stroke. Worried lest her daughters discover the vibrator next to her body, she decided to dispose of it.

Similarly, University of Washington Professor of Nursing, Patricia MacElveen-Hoehn, observed:

> ... the sexually conservative woman who returns home for the funeral of a parent or some close relative and takes with her a diaphragm and uncharacteristically engages in a sexual relationship with a stranger or casual friend; or the man who has a severe coronary and on the way to the hospital fondles his wife's breasts and presses for some sexual exchange; or the man who, with a child dying of leukemia, becomes highly promiscuous.[3]

Note that in these examples a salient feature of each instance is the uncharacteristic manifestation of the person's sexual behavior. Each of these individuals had no history of problematic, impulsive, or compulsive sexual acting out. It was only in the presence of death, and the terror that resulted from an

unconscious confrontation and consideration of their mortality, that their sexual behavior aggressively presented in an apparent attempt to ward off the dread and anxiety of death.

Consider the following case presented by Yalom[3]:

> Tim was a 30-year-old patient whose wife was dying of leukemia. Tim began therapy not because of overt grief but because of an alarming degree of sexual preoccupation and compulsivity. He had led a monogamous life prior to his wife's illness, but as she approached death, he began compulsively to visit pornography films and singles' bars (running great risks of public exposure) and masturbated several times a day, often while in bed with his dying wife. On the night of his wife's funeral he sought out a prostitute.

Note the uncharacteristic escalation and intensity of sexual behavior displayed by Tim. It is significant that his sexual behavior appeared to be in direct relation to his dealing with his wife's illness and impending death. For Tim, not only was he confronted with the terror that accompanies the early death of a loved partner, but also it likely resonated in Tim's unconscious that if this could happen to his wife, his own existence was much more tenuous than he had ever considered.

Let us look more closely at some clinical presentations of this phenomenon from my actual case presentations. Although the details of the following cases have been altered to protect the privacy of the patients, each of these narratives comes from authentic patient accounts.

CASE EXAMPLES OF DEATH ANXIETY AND HYPERSEXUALITY OR SEXUAL ADDICTION

As articulated earlier, each individual in the cases discussed below displayed an uncharacteristic escalation of sexual behavior after a confrontation with mortality. In addition, there is often a foreboding sense of one's existence being fragile, and that one will suffer an early death. Many of these men and women had early life encounters with death. Similar to Ebenezer Scrooge, they experienced the early, and unexpected, death of a sibling, parent, or other person of significance in their younger years. Men whose fathers died young often live with the specter of early death stalking them throughout their lives. One particularly poignant representation of this is embodied in the work of folksinger, Louden Wainwright III. Wainwright's father died when he was young and Wainwright had long lived with the fear that he would not live longer than his father had. When he passed his father's age of death, he was filled with emotion and his next album release was a compilation of songs expressing his unrestrained reactions to his own sense of death terror. In the liner notes from his album, *Older Than My Old Man Now,* he wrote:

> If I remain still, if I am alone and silent long enough to hear the sound of my own blood or breathing or digestion above the rustling of leaves or the whir of the refrigerator, my father is likely to turn up. He just arrives unbidden in the long running film of my thoughts, like Hitchcock in his pictures, and he looks for all those 40-plus years of disembodiment much like himself, big and sandy haired with freckles on the backs of his hands, perhaps a bit more diffident in the way he holds himself than I remember. He doesn't stay long, and as far as I can tell his visits have no message. Yet—even though years of therapy have led me to make the dark whistling claim that he's finally dead and gone—my father, who died when I was 17, continues to be my principal ghost, a lifelong eminence grise, and only my own end will finish it.[33]

Wainwright's words clearly express the petrifying sensations of being pursued by the menacing shadow of death that is characteristic of so many of the patient narratives we will examine.

Each of the following cases presented as self-identified sex addicts. Although they could not identify a death-terror–inducing incident at intake, all eventually linked their uncharacteristic progression into uncontrolled sexual behavior to a death-terror–inciting event. The particulars of each case have been altered to preserve the confidentiality of the patients.

Case 1: Simon

Simon was a 54-year-old married man when I first saw him for consultation. He reported a stable, conventional, monogamous life. He and his wife had been married for approximately 25 years, and he reported a very satisfying work, family, and sexual life. Of note was the early death of Simon's father from a myocardial infarction (MI) at 53 years of age. Simon was deeply affected by the unexpected and early loss of his father and reported that he often felt he would not live longer than 53 years. Simon reported feeling from 50 years on that he was "just waiting to die." As Simon approached his 54th birthday, he recalled feeling some optimism and relief thinking he was going to live beyond the age of his father. One week before Simon's 54th birthday he was diagnosed with prostate cancer and opted to undergo radical prostatectomy. Simon was stunned, and approximately 5 months after surgery he began frequenting strip clubs, massage parlors, and prostitutes. This behavior escalated in frequency with Simon reporting that it felt "obsessive" and "uncontrollable." He impulsively decided he had to leave his job and his marriage and began a frenetic journey around the country seeking sexual adventure. He had sexual interactions with men and women until he became so distraught at being unable to achieve penile erection that he attempted suicide in a hotel room in Phoenix, Arizona. After a brief hospitalization he returned home and began psychotherapy.

Simon's case, although extreme in aspects of its presentation, is not atypical of cases of hypersexuality after a confrontation with mortality. Notable is the early death of his father, Simon's fear that he, too, would die young, and the uncharacteristic, and seemingly uncontrollable, sexual spree that followed his cancer diagnosis. When asked about the uncharacteristic nature of his behavior (these were his first same-sex sexual experiences), Simon reported that he was looking to feel "alive" and sought out all types of sex in an effort to feel a "spark."

Case 2: Oliver

At 49 years of age, Oliver sought consultation because he was in the process of being divorced for the 3rd time. Each of his divorces was precipitated by his wives' discovery of his sexual involvement with other women. The most recent infidelity occurred with his current wife's sister. Oliver reported that each of his wives knew about only a fraction of his extramarital sexual activities, and that he spent much of his non-working time engaged sexually with other women. Oliver estimated that he had had extramarital sexual relations with more than 100 women. During our first psychotherapy session, Oliver was clearly distressed. He was at a loss to explain his sexual behavior because he reported being deeply in love with each of his wives and having a very satisfying sex life with each. He said his sexual urges felt obsessive and irrepressible, and although he often vowed to stop, he was unable to do so.

Oliver reported a difficult childhood. His mother had severe mental illness and was often hospitalized for long periods. Even when she was home, her illness left her unable to provide much childcare or family engagement. Oliver's father died young, and this left much of the responsibility for childcare of his younger brother and sister to Oliver as the oldest child. When asked if he could recall when his sexual behavior began to feel unmanageable, Oliver quickly responded with, "Absolutely. It began right before my 35th birthday." Knowing that Oliver's father died young, I expected to discover that his death occurred at 35 years. However, Oliver reported that his father died of an MI at 62 years. In examining his father's death more closely, Oliver stopped speaking mid-sentence and was stunned to recall that although his father had, indeed, died at 62, the fatal MI had been his 3rd MI. His first MI occurred at 35 years.

Of note in Oliver's case is his clear recollection of the starting point for his uncharacteristic sexual behavior. Too often, sex therapists neglect to ask about the timeline of events or do not diligently mine the timeline for relevant details that illuminate the meaning and significance of the sexual behavior. Rarely is the timing of the activation of the altered pattern of sexual behavior insignificant.

Case 3: Steven

Steven was a 44-year-old married man who had been with his wife for more than 18 years. He reported a companionable, pleasant, but unsatisfying married life. In the years before consultation, Steven reported feeling increasingly "controlled" by his wife, saying his marriage had left him feeling a "loss of vitality." He further reported feeling like a "ghost in his own home."

Steven recalled being raised in a highly dysfunctional home. He recollected being the frequent mediator between warring parents. He remembered crying uncontrollably as a child fearing death and loss, the likely result of having such an unstable family life. As an adult, he continued to be preoccupied with thoughts of death. Approximately 2 years before consultation, Steven unexpectedly lost his father-in-law because of unanticipated complications from a routine surgical procedure. He described this as a tremendous loss, because he felt much closer to his father-in-law than he did to his own father. After his father-in-law's death, Steven became preoccupied with the sense of "running out of time" and felt catapulted into a feverish pursuit of sexual excitement. Monogamous up to this point, Steven felt himself driven to "shock himself" and "be courageous and try new things." He became increasingly preoccupied with the fear that he was missing out on too much of life and needed to "do something to feel alive." He found himself focused on sex with men and had multiple extramarital same-sex sexual experiences. This behavior continued until his wife discovered his infidelities, and he agreed to seek psychotherapy.

Steven's story is significant for several reasons. His frequent references to death (ie, feeling like a ghost in his own home, his loss of vitality, and needing to do something to feel alive) are not uncommon in these cases. Often there is a sense of being "dead" or "lifeless" that is expressed in the description of many of these patients' experience of their existence, and they present as desperately seeking the verve of aliveness. Steven was acutely aware that he was getting older and that life could be taken when least expected. This created a panic, or terror, in him that propelled him to urgently seek a more meaningful and fulfilling life.

Earlier in this article, I wrote of Yalom's[10] observation that "though the physicality of death destroys us, the idea of death may save us." The leitmotif in this statement is that the fear of death can be a powerful motivator for change. Often, as in the case of Ebenezer Scrooge, that change can be life enhancing. For Steven, this also turned out to be the case. Through therapy, Steven was able to come to terms with his desires for a life with another man. In his family of origin, being gay was considered wholly unacceptable. Steven had internalized much of the homophobic attitude of his family and denied his own authentic sense of himself as a gay man. The unexpected death of his father-in-law created a terror in Steven that he would live his entire life in a disingenuous existence and his protective unconscious was empowered to thrust Steven into confronting the reality that he had long denied. The result was his courageously engaging in a life that was genuine, meaningful, and fulfilling.

Case 4: Patricia

Patricia was a 51-year-old woman who reported being happily married for 27 years. She reported marrying her high school

sweetheart and always being monogamous. As she passed her 50th birthday, the last of her 3 children left for college, and she was preparing to downsize her home, she began to experience uncharacteristic panic attacks. She was aware of being preoccupied with thoughts of aging, running out of time, and feeling suffocated by her life. She was overpowered with an urge for freedom, autonomy, and independence that culminated in a splurge of extramarital sexual activity that felt obsessive and reckless. Her husband discovered her affairs, and she decided to seek consultation.

Patricia did not recall any early death experiences in her history. However, she reported feeling very constrained in her family of origin and was raised with the admonition that "good girls don't display negative emotions." As a result, she often felt obligated to do what she believed was expected of her. She married, in large part, to get out of the house and conform to her family of origin's value system. Although she described her husband as being a very good man, she found her marriage happy but dull and unfulfilling (ie, lifeless). As she became more acutely aware of the passage of time and her own aging, she was plagued by thoughts that she had yet to live the life she craved. The theme of running out of time became palpable, and her attempts to repress those feelings exploded in the form of panic attacks. Eventually, her efforts to suppress her desires for freedom, independence, and the life she coveted gave way to the surge in sexual feelings that made her feel alive, vibrant, and free.

TREATMENT

As mentioned earlier, existential psychotherapy focuses less on the presenting symptom(s) per se and more on the meaning the symptom(s) has for the individual. In the cases described earlier, the changes in sexual behavior appear to be the result of a confrontation with mortality and the ensuing terror of death. For these patients, their uncharacteristic sexual behavior represents an attempt to find vitality and solace through the explosive expression of sexuality. As the death terror persists, the behavior increases in intensity, frequency, and variety. As a result, treatment is aimed not at the sexual behavior directly but rather at the fear of death that precipitated and fueled the unmanageable and problematic sexual activity.

In existential therapy, the belief is that symptoms are often overdetermined and are expressions of attempts to defend the individual against existential anxieties (ie, in these cases, the terror of death). Therefore, treatment focuses on soothing the death terror and loss as opposed to the sexual behavior per se. Therapy looks to give "meaning" to the symptom(s), and it is through an in-depth exploration of the meaning of the presenting symptom(s) that the healing takes place. In each of the cases described earlier, the uncharacteristic expression of unmanageable sexual behavior was triggered by an unanticipated confrontation with mortality or the threat of non-existence. None of the individuals were aware of what was driving their sexual behavior, and it was only through the mindful realization of the role that death terror played in their lives did they regain control and manageability over the expression of their sexuality.

CONCLUSION

The central thesis throughout this article is that sex therapists and other sexual medicine specialists need to retain a discerning view of the complex psychological dynamics and dilemmas that can fuel problematic sexual behavior. Oftentimes, existential issues such as freedom, responsibility, isolation, meaninglessness, and death can create a disruption in sexual behavior that can be confusing, disconcerting, and seemingly impenetrable. Although sexual medicine and traditional sex therapy techniques can often alleviate sexual suffering, there are times when a more in-depth psychotherapy is needed to get to the root cause and ultimate assuagement of the presenting sexual symptoms. Existential psychotherapy is one such form of treatment that allows clinicians to probe the subterranean depths of the human psyche and make meaning of one's sexual behavior and its vagaries.

In this article, we examined the existential issue of death terror as a trigger for hypersexuality, or sexual addiction. Although certainly not all cases of hypersexuality are precipitated by a confrontation with mortality and death, there are cases in which sex is imbued with meaning as an antidote to the fear of death. When evaluating cases of hypersexuality, clinicians should carefully explore the timeline of the change in sexual behavior and inquire about the timing of the behavior's origination and its relation to terror regarding death. Future articles will explore the existential issues that can manifest in the etiology of other sexual difficulties and dysfunctions.

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