Sexual Addiction And Its Management: A Review

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Abstract

Sexual addiction, otherwise known as compulsive sexual behaviour, is an emerging psychiatric disorder that has significant medical and psychiatric consequences. Little data exists to explain the biological, psychological, and social risk factors that contribute to this condition, though significant number of patients are seen in communities and psychiatric hospitals. This article reviews the clinical features of compulsive sexual behavior and summarizes the current evidence for psychological and pharmacological treatment.

Defining sexual addiction

The DSM-IV and DSM 5 does not include sexual addiction behavior as a separate disorder with formal criteria. There are 12 listed sexual disorders and they are divided into disorders of sexual dysfunctions, paraphilias, and gender identity disorders [1]. Among these disorders, there is no mention of repetitive, continued sexual behaviors

that cause clinical distress and impairment. In fact, the only place where sexual addiction might be included is within the context of sexual disorder, not otherwise specified or as part of a manic episode. In other words, hypersexuality, sexual addiction, or compulsive sexual behaviors are terms that are not found within the diagnostic criteria.

The main reasons for lack of formal criteria are absence of ample research and an agreed-upon terminology. This is due, in part, to the heterogeneous presentation of sexual addiction behaviors [2]. For instance, some patients present with clinical features that resemble an addictive disorder i.e., continued engagement in the behavior despite physical or psychological consequences, loss of control, and preoccupation with the behavior. Others will demonstrate elements of impulse control disorder, namely irresistible urges and impulses, both physically and mentally, to act out sexually without regard to the consequences. Finally, there are patients who demonstrate sexual obsessions and compulsions to act out sexually in a way that resembles obsessive compulsive disorders.

Sexual drive can be seen as similar to other biological drives, such as sleep and appetite. States of hypersexuality, induced by substances of abuse, mania, medications (e.g. dopamine agonists), or even other medical conditions (e.g. frontal-lobe tumors) can induce episodes of impulsive and excessive sexual behaviors [3]. If the primary conditions are treated, the sexual behaviors return to normalcy in terms of frequency and intensity.

Epidemiology

There have been no studies documenting the past-year or lifetime prevalence of compulsive sexual behaviors in the general population. Regional and local surveys suggest that approximately five percent of the general population may meet criteria for a compulsive sexual disorder (using criteria that are similar to substance use disorders) [4]. The reasons, why reliable epidemiological data are lacking is the inconsistency in defining criteria for sexual addiction and also lack of researchers committed to documenting the extent of this problem. Many people also don't think this as a problem. Men appear to outnumber women with sexual addiction disorders [4]. Majority of sexual addiction cases have comorbidity like substance use disorders, impulse control disorders [5,6].

Etiology of sex addiction

There is no single biological cause that has been identified to explain the origins and maintenance of sexual addiction disorder. Neuroimaging studies show similar results for the patients with sexual addiction, substance addiction and other behavioral addictions. Hypersexual behaviors have been reported in patients with frontal lobe lesion, tumors, and in those with neurological conditions that involve temporal lobes and midbrain areas such as seizure disorders, Huntington's disease, and dementia [7,8,9].

Neurotransmitter studies in sexual addiction have focused on the monoamines, namely serotonin, dopamine, and norepinephrine [10]. Still there is lack of sufficient research in clinical populations. Normal sexual functioning involves all of these monoamines as evidenced by selective serotonin reuptake inhibitor (SSRI) induced sexual dysfunction and increased sexuality is observed among those on stimulants. Cases of hypersexual behavior have also been shown to be induced by medications for Parkinson's disease,

implicating dopamine systems in sexual addiction behaviors [11].

Sex hormones are also a critical component to sexual addiction. Testosterone levels have been correlated to sexual functioning [12]. The reward and pleasure are modulated by these hormones through facilitating or enhancing the response to sex and the desire for sex.

Clinical features of sex addiction

Sexual addiction behaviors can present in a variety of forms and degrees of severity, like that of substance use disorders, mood disorders, or impulse-control disorders. Many a times, it may not be the primary reason for seeking treatment and the symptoms are not revealed unless inquired about. The individual is excessively preoccupied in sexual activities, excessive and intrusive thought or image about sexual activity despite the negative consequences created by these activities. This is like the same phenomenon seen in substance use and impulse control disorders. Psychologically, sexual behaviors serve to escape emotional or physical pain or are a way of dealing with life stressors [13]. The irony is that the sexual behaviors become the primary way of coping and handling problems that, in turn, creates a cycle of more problems and increasing desperation, shame, and preoccupation. The patient may develop secondary depressive symptoms. These symptoms can be categorized into paraphilic and nonparaphilic subtypes.

Paraphilic behaviors refer to behaviors that are considered to be outside of the conventional range of sexual behaviors. Paraphilias recognized in the DSM IV include exhibitionism, voyeurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, fetishism, and frotteurism [1]. There are many other forms of paraphilias that are not listed in DSM-IV (e.g., gerontophilia, necrophilia, zoophilia) that exist but have not been yet recognized as clinical disorders. Paraphilias usually begin in late adolescence and peak in the mid- twenties [14].

Non-paraphilic behaviors represent engagement in commonly available sexual practices, such as attending strip clubs, compulsive masturbation, paying for sex through prostitution, excessive use of pornography, and repeated engagement in extramarital affairs. The onset, clinical course, and male predominance are fairly similar to paraphilic disorders [15].

A significant consequence of sexual addiction is the loss of time and productivity. It is not uncommon for patients to spend large amounts of time viewing pornography or cruising (also called mongering) for sexual gratification. Financial losses can mount quickly. In addition, there may be a long list of legal consequences, including arrest for solicitation and engaging in paraphilic acts that are illegal. One look at recent news headlines is likely to reveal several stories focusing on illegal sexual activities or behaviors that jeopardize someone's livelihood or wellbeing.

The psychological consequences are also numerous. Effects on the family and interpersonal relationships can be profound. The deception, secrecy, and violations of trust that occur with sexual addiction may shatter intimacy and personal connections. The result is a warped intimacy that often leads to separation and divorce and, in turn, puts any future healthy relationship in doubt.

Clinical assessment measures

Patrick Carnes, one of the pioneers in the field of

sexual addiction research, developed the 'Sexual Addiction Screening Test', which is a 25-item, self-report symptom checklist that can be used to identify those at risk to develop compulsive sexual behaviors [16]. The 'Sexual Addiction Screening Test' has also been modified for women and for internet sexual behaviors. Kafka has suggested a behavioral screening test 'Total Sexual Outlet' in which a total of seven sexual orgasms per week, regardless of how they are achieved, could represent at-risk behavior and requires further clinical exploration [17].

Psychological treatment

Inpatient and outpatient treatment programs for sexual addiction usually focus on helping to identify core triggers and beliefs about sexual addiction and to develop healthier choices and coping skills to minimize urges and deal with the preoccupation with sexual activities.

Motivational interventional therapy, cognitive behavior therapy, and couples and family therapy have been shown to be potent interventions for several forms of drug and behavioral addiction [18,19,20]. Behavioral therapies may be associated with reductions in substance use and may have effects on the neural systems that are involved in cognitive control, impulsivity, motivation and attention [21]. These effects may also benefit in patients with sexual addiction.

Group therapy is an adjunct to therapeutic possibility [22]. Family therapy and couples therapy may re-establish the trust, diminish shame/guilt, and establish a healthy sexual relationship between the partners [23].

In USA, 'Sexual Addicts Anonymous', 'Sex and Love Addicts Anonymous', and 'Sexaholics Anonymous' are used for the treatment of sexual addiction [24]. The basic principles of this therapy is based on twelve steps and twelve traditions of 'Alcoholics Anonymous'.

Pharmacotherapy

There is no Food and Drug Administration (FDA) approved medications for sexual addiction behaviors in USA. Evidence only comes from preliminary case reports and open-label trials [12]. Various classes of medications have been tried, including antidepressants, mood stabilizers, antipsychotics, and antiandrogens. The rationales for these drugs are based on clinical phenomenology and symptoms. In addition to SSRIs, naltrexone, an opiate antagonist, has been evaluated in the treatment of sexual addiction [25]. The rationale for using this medication is based on previous work in substance abuse populations and pathological gamblers, where the intent is to reduce the cravings and urges by blocking the euphoria associated with the behavior. In an open-label trial of naltrexone with adolescent sexual offenders, 15 out of 21 patients noted reductions in sexual impulses and arousal [26]. There have also been studies examining the efficacy of intramuscular naltrexone in this clinical population.

Mood stabilizers, such as valproic acid, carbamazepine and lithium, appear promising in the treatment of patients with bipolar disorder and impulsive disorder [27]. Whether this class of medications has an independent effect on reducing sexual addiction in patients without comorbid bipolar disorder remains to be seen. Other medications, such as topiramate and nefazadone, have also been tried [28].

Chemical castration by using

antiandrogens, such as medroxyprogesterone acetate (300–500mg per week, intramuscularly) or cyproterone acetate (300–600mg per week, intramuscularly), lower serum testosterone level and diminish sexual drive and desire [29].

A more drastic, surgical intervention (castration) has been shown to reduce recidivism in sexual offenders by theoretically lowering testosterone levels to reduce urges and cravings.

Conclusion and future directions

Sexual addiction disorder is the extreme end of a wide range of sexual experiences. These behaviors can present in a variety of ways and have different subtypes, severities, and clinical courses. Future research can enhance early identification and treatment of these disorders by developing clinical screening guidelines, by identifying the warning signs and by assessing the vulnerable patients and common comorbidity.

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- *Aims to facilitate the integration of knowledge and expertise across various disciplines like medicine, psychology, sociology, law and ethics for greater understanding of complexities of human sexuality*
- *Aims to adequately address the individual sexual problems and social issues*

Objectives

- *To bring experts of different disciplines to a common platform for sharing of knowledge and views on human sexuality*
- *To promote research on human sexuality*
- *To impart training on 'Sexology' and strengthen the discipline of 'Sexual Medicine'*
- *To encourage medical professionals to choose 'Sexual Medicine' as a career*
- *To create public awareness on human sexuality and gender issues*
- *To advocate any social change for betterment of mankind*