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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

BEHAVIORAL ADDICTION: SEX ADDICTIONS

TIMOTHY M HALL MD PhD FAPA FASAM

CENTER FOR BEHAVIORAL & ADDICTION MEDICINE

UCLA DEPT OF FAMILY MEDICINE

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OBJECTIVES

1. Describe the challenges in the evidence base for proposed “sexual addiction”, “hypersexual disorder”, or “compulsive sexual behavior disorder”
2. Describe three categories of problematic sexual behaviors that present clinically
3. Implement or refer to evidence-based treatments for problematic sexual behaviors

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SEXUAL ADDICTION: MOSTLY NOT A THING

"Sexual addiction" is mostly not a thing

We do see many people with problems related to sex, but little evidence for a nonspecific, elevated sex drive that causes compulsive sexual behavior for any outlet

Lack of agreement on definition

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SEXUAL ADDICTION: LIMITS OF ADDICTION METAPHOR

Little evidence supporting **addiction** as useful metaphor:

1. Little evidence of tolerance/withdrawal
2. Lack of medication-assisted therapies
3. Neuroimaging inconsistent with SUDs
4. Treatments modeled on SUDs may be harmful – enhancing sexual shame, interfering with healthy relationships

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SEXUAL ADDICTION: MOSTLY SOMETHING ELSE

1) mood, anxiety, or obsessive-compulsive disorder
2) substance use disorder
3) personality disorder (e.g., borderline personality disorder or antisocial personality disorder)
4) impulse-control disorder, including organic impulse control disorders such as traumatic brain injury
5) trauma history, relationship problems, or internalized negative attitudes about sexuality
6) specific paraphilic disorder such as exhibitionism, frotteurism, voyeurism

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HIGH VOLUME SEXUAL BEHAVIORS (HVSB)

1. Multiple constructs
2. Disagreement over definitions
3. Rejected from DSM-V for lack of rigorous evidence

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HVSB: APPEARANCE

Patients report excessive time planning or engaging in sexual behaviors, either alone or with partners. Hours spent on the internet or dating apps seeking sexual connections, engaging in sex, attending strip clubs or sex clubs, or masturbating to pornography. Individuals complain of sexual behaviors experienced as repetitive, persistent, compulsive, and out-of-control. When not engaged in the behaviors, individuals report obsessive thoughts about sex.

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CASE STUDY: "MIKE"

Late 40s, GWM, well controlled HIV since his 20s. Hours each day on dating apps, goes to sex clubs and sex parties. Sometimes multiple sex partners per day. Bodybuilder on anabolic steroids and HGH, has also undergone multiple cosmetic surgeries, including filler injected into penis, buttocks, biceps. Some sexual performance problems due to enlarged penis, age, other medications.

Increasingly preoccupied with appearance and need for new sexual partners as he gets older.

Dx: narcissistic personality disorder and body dysmorphic disorder

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Proposed Criteria for Hypersexual Disorder - Kafka (2010)

A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors in association with 3 or more of the following 5 criteria:
A1. Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other important (non-sexual) goals, activities and obligations.
A2. Repetitively engaging in sexual fantasies, urges or behaviors in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
A3. Repetitively engaging in sexual fantasies, urges or behaviors in response to stressful life events.
A4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviors.
A5. Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.
B. There is 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.
C. 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) Specify if: Masturbation, Pornography, Sexual Behavior with Consenting Adults, Cybersex, Telephone, Sex Strip Clubs, Other

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Proposed Criteria for Sexual Addiction - Goodman (1992)

A. Recurrent failure to resist impulses to engage in a specified sexual behavior
B. Increasing sense of tension immediately prior to initiating the behavior
C. Pleasure or relief at the time of engaging in the sexual behavior.
D. At least five of the following:
1) frequent preoccupation with the sexual behavior or with activity
2) frequent engaging in the sexual behavior to a greater extent
3) repeated efforts to reduce, control, or stop the sexual behavior
4) a great deal of time spent in activities necessary for the sexual behavior, engaging in the sexual behavior, or recovering from its effects
5) frequent engaging in the sexual behavior when expected to fulfill occupational, academic, domestic, or social obligations
6) important social, occupational, or recreational activities given up or reduced because of the sexual behavior
7) continuation of the sexual behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the sexual behavior
8) tolerance: need to increase the intensity or frequency of the sexual behavior in order to achieve the desired effect, or diminished effect with continued sexual behavior of the same intensity
9) restlessness or irritability if unable to engage in the sexual behavior.
E. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

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Proposed Criteria for Sexual Addiction - Carnes et al. (2012)

Three or more of the following symptoms:

1) Recurrent failure to resist impulses to engage in specific sexual behavior
2) Frequent engaging in sexual behaviors to a greater extent or over a longer period of time than intended
3) Persistent desire or unsuccessful efforts to stop, reduce, or control sexual behaviors
4) Inordinate amount of time spent in obtaining sex, being sexual, or recovering from sexual experience
5) Preoccupation with sexual behavior or preparatory activities
6) Frequent engaging in sexual behavior when expected to fulfill occupational, academic, domestic, or social obligations
7) Continuation of sexual behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behavior
8) Need to increase the intensity, frequency, number, or risk of sexual behaviors to achieve the desired effect, or diminished effect with continued sexual behaviors at the same level of intensity, frequency, number, or risk
9) Giving up or limiting social, occupational, or recreational activities because of sexual behavior
10) Distress, anxiety, restlessness, or irritability if unable to engage in sexual behavior

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COMPULSIVE SEXUAL BEHAVIOUR DISORDER (CSBD): ICD-11: 6C72

“Compulsive sexual behaviour disorder is characterised by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour. Symptoms may include repetitive sexual activities becoming a central focus of the person’s life to the point of neglecting health and personal care or other interests, activities and responsibilities; numerous unsuccessful efforts to significantly reduce repetitive sexual behaviour; and continued repetitive sexual behaviour despite adverse consequences or deriving little or no satisfaction from it. The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behaviour is manifested over an extended period of time (e.g., 6 months or more), and causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviours is not sufficient to meet this requirement.

Exclusions

- Paraphilic disorders (6D30-6D3Z)”

ICD-11 for Mortality and Morbidity Statistics (Version : 05/2021; accessed 5/25/2021) https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1630268048

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CANTOR'S TYPOLOGY (2012)

Case series presenting to Sexual Behaviours Clinic of the Centre for Addiction and Mental Health, Toronto, Canada:

- Paraphilic Hypersexuality
- Avoidant Masturbation
- Chronic Adultery
- Sexual Guilt
- The Designated Patient
- Better Accounted for as a Symptom of Another Condition

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CANTOR'S PARAPHILIC HYPERSEXUAL

- ⅓ of hypersexuality referrals to SBC
- Initially report extremely high frequencies of one or more sexual behaviors, sufficient to cause distress.
- Behaviors: chronic adultery, hours per day viewing pornography or seeking sexual partners online, and frequent solicitation of prostitutes.
- Later report multiple, often low-grade paraphilic interests.
- Tend to seek novelty, move from one to another
- Usually don't meet full criteria for a paraphilic disorder and often don't stick with one focus
- Consider SSRIs

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CANTOR'S AVOIDANT MASTURBATOR

- Patients are mostly male
- Report masturbating several hours per day, having been fired from jobs for seeking online pornography or masturbating during work hours, failing classes, forgoing other major life activities to spend the time masturbating.
- Mostly very conventional porn themes
- Used to procrastinate or avoid tasks, conflicts, and boredom
- CBT may be best approach

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CANTOR'S CHRONIC ADULTERY

- Less common, but main focus of media coverage
- Generally few paraphilic interests
- ***Don't*** spend excessive time looking for sex
- Many extramarital encounters, often one-off or with sex workers
- Common pattern: marital conflict, discrepancy in sex drive, spouse unable or unwilling to have sex often
- Marital counseling, often in fraught relationship

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CANTOR'S SEXUAL GUILT

- Common presentation: report great distress over sexual behaviors (frequency of intercourse, masturbation, adultery, pornography use) that are within normal range
- Or very conflicted about same-sex attraction
- Hold very negative views about sexuality, often from religious background
- May have prior dx of mood or anxiety disorder
- Psychotherapy and psychoeducation

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CANTOR'S DESIGNATED PATIENT

- Referred by spouse or partner, often over masturbation, pornography viewing, or infidelity
- Partner has very negative attitudes towards sex, "zero tolerance" for masturbation, etc.
- include the partner in counseling
- psychoeducation regarding healthy masturbation and pornography use
- communication and assertiveness training

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OTHER DISORDERS

Need to look for other symptoms which may suggest a primary disorder

- Borderline personality disorder – may act out sexually, jump from one intense relationship to the next
- Bipolar disorder
- Sexual behaviors in context of substance use disorder
- Other impulse control disorders

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CASE STUDY: "JOSH"

Mid 30s, heterosexual WM, Iraq war vetera. Experienced personality changes following TBI and return to civilian life, unable to hold a job due to angry outbursts, poor concentration, poor impulse control. Intermittent binge drinking. Fondled stepdaughter, arrested, divorced. No prior evidence of attraction to minors or of unusual sexual behavior.

Dx: likely due to TBI and poor impulse control.

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HISTORICAL CONSIDERATIONS

Long history of medical establishment stigmatizing sexual variation:

- sexual attraction to adults of the same sex
- masturbation (*onanism*)
- conceiving a child outside of marriage
- “feminine” behavior in a man
- any expression of sexual desire in a woman

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HISTORICAL CHANGE

- US currently undergoing cultural change in regard to sexual behaviors and relationships
- masturbation (*onanism*)
- conceiving a child outside of marriage
- “feminine” behavior in a man
- any expression of sexual desire in a woman

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PARAPHILIC DISORDERS DSM-V

- paraphilia is "intense and persistent sexual interest othaser than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners."
- "a paraphilia by itself does not necessary justify or require clinical intervention"
- *paraphilic disorder* is "a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others."

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PARAPHILIA: DIAGNOSIS

- Individual instances of acting out sexually do not constitute paraphilia
- Need evidence of distress or impairment to diagnose paraphilic **disorder**
- Majority of sexual assault and sex crimes are not driven by paraphilia
- Majority of perpetrators of child sexual abuse are not pedophiles

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PARAPHILIC DISORDERS

- voyeuristic disorder,
- exhibitionistic disorder,
- frotteuristic disorder,
- sexual masochism disorder,
- sexual sadism disorder
- pedophilic disorder
- fetishistic disorder
- transvestic disorder
- other specified paraphilic disorder

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PARAPHILIA CATEGORIES

Anomalous activity preference:

- Courtship disorder hypothesis:
  - voyeurism, exhibitionism, frotteurism, telephone scatologia
- Algolagnic
  - sexual masochism disorder, sexual sadism disorder

Anomalous target preference,

- pedophilic disorder – not adult
- fetishistic disorder – not a whole person
- other specified paraphilic disorder

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PARAPHILIA: NEED FOR TREATMENT?

- “a paraphilia by itself does not necessary justify or require clinical intervention”
- Paraphilic behaviors are common: surveys find ~ 4 – 30% of adults surveyed endorse at least occasional activities or fantasies
- Growing awareness and openness to “kinky” behaviors with cultural change
- Orientation-like quality of strongly felt paraphilias – very hard to change, likely better to integrate into personality if they are harmless

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CASE STUDY: “GREG”

Mid 50s, heterosexual WM, graduate degree. No long-term romantic relationships. History of attending strip clubs, engaging sex workers, previously briefly involved with a stripper he paid for girlfriend experience. Informed therapist he was taking photos of attractive women in public; behavior has diminished with CBT, social activation therapy.

Dx: voyeuristic disorder, possible ASD, MDD

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SEX OFFENDER REGISTRIES

Many unintended effects

Overly broad: hard for police and social workers to focus on offenders at high risk because so many low-level offenders listed

Many states include public urination or public nudity (penalizing homeless or intoxicated)

Not focused on forensic assessment of risk of reoffense (generic sex offenders actually lower risk than many other criminals of reoffense)

Many states criminalize common behaviors like teen sexting or sexual relations between adolescents

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SEX OFFENSES – ACTING OUT

Major risk factors for committing criminal sexual acts

- Antisocial personality disorder
- Other personality disorders
- Impulse control disorders
- Comorbid substance use disorders

Paraphilic disorder alone is much lower risk unless combined with these

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SUD + COMPULSIVE SEX

- Long history, but may be more problematic with methamphetamines ± club drugs (especially MDMA, GHB)
- Drug use and sex can be mutually reinforcing
- Little evidence base for treating the combination
- Need more research and tailored programs

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SEX & GENDER MINORITY POPULATIONS

- Particular challenge because of history of stigmatizing variant sexual behaviors among LGBT populations
- May be dealing with shame, internalized homophobia, biphobia, transphobia, or HIV stigma
- Many clinicians/programs not experienced with sex and gender diverse patients

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SGM HEALTH CONSIDERATIONS

- Cisgender men, transgender women, and trans men who have sex with male partners may be at higher risk of HIV and viral hepatitis
- May use drugs or alcohol to mitigate shame around sexual behaviors
- Particularly sensitive to stigmatizing language
- 12-step or faith-based recovery programs may exacerbate stigma

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PHARMACOTHERAPY - SSRIs

- SSRIs for mild paraphilias, in adolescents with paraphilic disorders (suggestion it may help mute development)
- comorbid OCD or depression
- Case reports of SSRI suppressing compulsive amputation fantasies
- Case reports of preserved normal sexual function with reduction in compulsions – highly patient-specific
- Fluoxetine and sertraline best studied

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PHARMACOTHERAPY – HORMONES 1

- Symptomatic rather than specific treatment: No evidence that paraphilic or CSBD patients have unusual levels of testosterone
- Synthetic steroidal analogs and GnRH analogs
- Suppresses testosterone through multiple mechanisms, suppresses overall sex drive and function
- Recommended by WFSBP but with weak evidence

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PHARMACOTHERAPY – HORMONES 2

- Cyproterone acetate (CPA)
- Binds to androgen receptors, ↓ intracellular uptake and metabolism of testosterone.
- Blocks GnRH secretion and LH release,
- Approved for individuals with paraphilic disorders in EU
- Hot flashes, hair loss, gynecomastia, weight gain, and osteoporosis
- Reduces risk of reoffense but not to zero
- Less effective if taken inconsistently

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PHARMACOTHERAPY – HORMONES 3

- Medroxyprogesterone acetate (MPA) is a synthetic progesterone derivative normally used for contraception and HRT
- weight gain (18 %), headache (9 %), gallstones (1 %), thromboembolism (1 %), elevated LFTs, hot flashes, insomnia, depressive symptoms, and adrenal suppression

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PHARMACOTHERAPY – GnRH ANALOGS

- triptorelin, leuprorelin, goserelin
- Developed for prostate cancer
- Testosterone drops to castrate levels within 1 month
- Small trials shows suppression of paraphilic behaviors in 1-3 months
- Side effects milder than synthetic steroids

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WFSBP ALGORITHM FOR PARAPHILIC DISORDERS

Escalating intensity of treatment based on risk of harm and distress to self and others

Goals:

1) Decrease fantasies and behavior that may lead to recidivism

2) Control sexual urges

3) Decrease level of distress

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WFSBP ALGORITHM FOR PARAPHILIC DISORDERS

- L1: mild paraphiliac thoughts/urges, slight distress, no harmful behaviors, +preserved conventional sexual function: psychotherapy, preferably CBT
- L2: mild impact on conventional sexual activity/desire or minor, non-touching inappropriate behaviors: SSRI at OCD doses
- L3: moderate reduction of conventional sexual activity/desire, “hands on” behaviors with fondling but without penetration, and paraphilic sexual fantasies without sexual sadism; add low-dose antiandrogen steroidal analog (MPA or CPA) to SSRI
- L4: paraphilias that substantially reduce conventional sexual activity/desire and carry moderate to high risk of sexual violence without sexual sadism. Consider full-dose antiandrogen steroidal analog, including IM formulation if patient is nonadherent.
- L5: paraphilias greatly interefere with normative sexual desire/activity, pose a high risk of sexual violence, or involve sexual sadism or physical violence; treat with long-acting GnRH agonist.
- L6: severe paraphilias, complete suppression of normative sexual desire and activity; consider CPA or MPA in combination with a GnRH agonist.

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12-STEP FOR SEXUAL ISSUES

Multiple "S" groups:

Sexaholics Anonymous (SA) repeated stances against same-sex relationships, only allows sex within a monogamous heterosexual marriage

Sexual Compulsives Anonymous (SCA) and **Sexual Recovery Anonymous** (SRA) – more LGBT-friendly

Sex and Love Addicts Anonymous (SLAA)

Sex Addicts Anonymous (SAA)

several companion groups for friends/family modeled on CoDA and Al-Anon

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12-STEP - DRAWBACKS

Problematic history: repeated splitting over doctrinal and definitional issues

Tendency to problematize normal sexual behavior

Explicitly religious, sectarian orientation

Several of these have history of homophobia/transphobia

Define acceptable sexual behavior very narrowly

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REFERRALS

No good evidence for residential programs for sex addiction.

Residential programs show little benefit over outpatient treatment for most addictive disorders, and suffer from lack of oversight, inconsistent use of evidence-based treatments, and poor quality control

Several for-profit centers and training programs, unclear evidence base, tend to further stigmatize behaviors

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REFERRALS

American Association of Sexuality Educators, Counselors, and Therapists (aasect.org)

- Provides evidence-based, sex-positive training in behavioral therapies for sexual disorders
- Referral database of clinicians
- CME opportunities

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