How to recognise sexual addiction in the sexual health clinic setting?

David Goldmeier,1 Jenny Petrak2

At what point does problematic or excessive sex become pathological? In STI and HIV clinic settings, we are familiar with the adverse consequences of having multiple partners which can include increased risk for STIs and HIV, unwanted pregnancies and significant relationship discord and distress. Kafka has recently reviewed the evidence for such excessive non-paraphilic behaviours with a view to a new classification in the American Psychiatric Association’s Diagnostic Manual of Mental Disorders due for publication in 2012 (DSM-V).1 He uses the term hypersexual disorder (HD) to encompass all such excessive non-paraphilic behaviour.

In practice in STI clinic settings and elsewhere there is anecdotal evidence of a growing clinical need for services for men and women presenting with self-defined ‘sexual addiction’.2 Recognising an HD is obviously important—not least because therapeutic help may be offered and given. The model proposed by Kafka goes some way in offering taxonomy of how excessive sexual behaviours could be categorised. Kafka2 has reviewed the various pathophysiological models for HD, which includes sexual desire dysregulation, sexual addiction and dependence, sexual compulsivity and impulsive/compulsive disorders. Of particular therapeutic interest is the sexual desire dysregulation, where it is suggested that dysfunctional cerebral monoamines (e.g., serotonin) interact with sex hormones to produce a biological substrate associated with increased sexual appetite as well as mood, anxiety and attention-deficit disorders and a propensity to substance abuse. Therapeutic options, which include cognitive-behavioural therapy (CBT) and selective serotonin reuptake inhibitor (SSRI) antidepressants, depend on clinical recognition of cases.

So how does one recognise HD? Kafka3 has suggested that the following diagnostic criteria are useful (see box 1).

Although HD carries a high risk of acquiring an STI where condom-less penetrative non-monogamous sex repeatedly takes place, other sexual outlets such as frequent masturbation, pornography, cybersex and telephone sex may be problematic for some individuals and are considered within the above criteria.

Some individuals may self-define their sexual behaviour as problematic or an ‘addiction’ and seek help, while typically a majority will not reveal or acknowledge that their specific behaviour may be part of a destructive pattern. Intense shame or guilt may also inhibit the disclosure of sexual issues. What signs then might lead physicians to identify when persons may be experiencing HD? How does the physician initiate discussion about HD?

Within STI clinics it is routine (although not necessarily experienced as routine for the patient) to enquire about the number of sexual partners, sexual practices, relationships, sex work and other intimate details. We may also have indicators of whether a sexual behaviour pattern is potentially becoming problematic; examples might include, frequent STI clinic attendance over a period of time, re-occurring STIs, multiple sexual partners, frequent infidelity and frequent contact with sex workers. It is also important to assess whether any of these behaviours are causing significant harm and distress to the individual and those around them. Examples of questions that the STI clinic physician may use for screening possible difficulties associated with HD are included in box 2.

In addition, it is unlikely that only one type of sexual behaviour (e.g., having multiple sexual partners) is affected in HD, and it is important to enquire whether the individual is spending significant amounts of time in, for example, excessive masturbation, use of erotica and internet porn. There are also a number of screening

---

1Jane Wadsworth Clinic, Jefferiss Wing St Marys Hospital, London, UK; 2Clinical Health Psychology, St Marys Hospital, London, UK

Correspondence to David Goldmeier, Jane Wadsworth Clinic, Jefferiss Wing St Marys Hospital, London W2 1NY, UK; david.goldmeier@imperial.nhs.uk

---

Box 1 Proposed diagnostic criteria for hypersexual disorder

Patients must fulfil criteria A, B and C

A. Recurrent and intense sexual fantasies, urges or behaviours over a period of at least 6 months that include three of the following five criteria
   - The fantasies, urges or behaviours repeatedly interfere with important non-sexual goals, activities or obligations (e.g., home or work)
   - Repeatedly engaging in sexual fantasies, urges or behaviours in response to dysphoric moods (e.g., depression, anxiety, boredom)
   - Repeatedly engaging in sexual fantasies, urges or behaviours in response to stressful life events
   - Repetitive but unsuccessful attempts to control the sexual urges, behaviours or fantasies
   - Repeatedly engaging in sexual behaviours while disregarding the physical risk (e.g., STIs) or emotional harm to self or others

B. There is associated personal distress or impairment in social, occupational or other important areas of functioning

C. The problem is not associated with a drug of abuse or a medication.

Box 2 Examples of questions for signs of hypersexual disorder

- Do you feel your sexual behaviour is often out of control?
- Do you often feel preoccupied with thoughts about sex?
- Has your sexual behaviour ever created problems for you, your partner or family?
- Is your sex life making it difficult for you to focus on other things in your life (e.g., work)?
- Do you feel you have to hide aspects of your sexual behaviour?
- Are you often left feeling low or depressed after sex?
- Have you ever made efforts to change some aspects of your sexual behaviour which resulted in relapse or failure?
- Have you ever sought any treatment to help with your feelings that you cannot control your sexual behaviour?
questionnaires that can be used to augment assessment including the Hypersexual Disorder Screening Inventory. 4

It is also very important that clinicians should enquire about psychiatric comorbidity. Various studies have suggested high rates of anxiety, depression, personality disorders and substance misuse in individuals with compulsive sexual behaviour. 5 Individuals with co-morbid mental health difficulties and substance misuse should be prioritised for referral for further assessment and therapeutic intervention (see box 3).

Having identified that HD may be present, the next step would be ensuring that referral is made to a clinician familiar in working with compulsive sexual difficulties. Within STI and HIV clinic settings, it is recommended that individuals are referred to internal or local clinical psychology, mental health or psychosexual services.

Therapy options can include CBT, individual, couples or family group therapy. In the last decade, there has also been the increasing expansion of the popular 12-step self-help programmes, for example, Sex Addicts Anonymous in the UK. These generally follow programmes similar to the 12-step programmes offered by Alcoholics Anonymous. There is also limited evidence for the effectiveness of medications, particularly high-dose SSRI antidepressants in the treatment of compulsive sexual behaviour. 6 Generally though there is, to date, little controller research into all of the above psychotherapeutic and pharmacological interventions. 7

It remains to be seen exactly how common HD is in general and clinical populations, although it has been long speculated that a minority sector of the population have a very high frequency of sex. A surrogate measure of HD may have been reported in the 2000 British National Surveys of Sexual Attitudes and Lifestyles (Natsal), where a high proportion of STI burden occurred in a small proportion of the population. Thus, half of the reported acute STIs in the previous 5 years were reported in less than 10% of the population who had 10 or more partners over this period. 8 As long ago as 1948, Kinsey found that 7.6% of American males (aged from adolescence up to 50) had a mean of seven or more total sexual outlets per week—meaning intercourse, oral sex, masturbation or any combination of these—for 5 consecutive years. Atwood and Gagnon reported similar findings in white American adolescent college students, where 5% of the 1077 surveyed reported at least 7 sexual outlets per week. 9 Kafka, however, points out in a recent review of HD that ‘excessive, repetitive or hypersexual behaviour without significant personal distress, volitional impairment or significant adverse consequences itself does not designate a clinical or pathological condition’. 3 An example of such behaviour might be watching internet porn for 15 min a day 5 times a week.

Nevertheless, the proposal of HD as a psychiatric diagnosis is likely to be greeted with considerable controversy. As ever, questions such as what is normative in sex or should behaviours which are essentially ‘normal’ be medically pathologised 10 will prevail. In addition, the authors believe that there is currently a lack of empirical knowledge to support HD, including aetiology. Significantly, there is little consideration in the model of the powerful social role of sex and cultural, ethnic, gender differences are not addressed. 11 Knowledge regarding HD in females is particularly lacking at present. There is also a need for further research evaluating therapies and treatments (psychological and pharmaceutical) for HD and associated behaviours.

It remains to be seen whether the new classification of HD will provide a useful way to identify and diagnose individuals. However, classifications or diagnoses will always be less important in the face of ensuring that the associated personal, relational and public health consequences of harmful sexual behaviours continue to be addressed in sexual health and HIV services.

**MULTIPLE CHOICE QUESTIONS (ANSWERS ARE PUBLISHED ONLINE)**

1. A 17-year-old boy with a religious background complains of recurrent erections during the day that disturb him. Is this likely to be a hypersexual desire disorder?
2. It is important for clinicians to enquire about psychiatric morbidity in patients with possible hypersexual disorder (HD)?
3. A heroin addict complains of intrusive sexual thoughts and unwanted sexual desire that disturb him since stopping opiates. Should he be treated with selective serotonin reuptake inhibitor (SSRI) antidepressants?
4. Patients with hypersexual desire disorder should always be given anti-psychotics along with cognitive behavioural therapy (CBT)?
5. A 32-year-old man has had chlamydia, gonorrhoea and syphilis in the last 8 weeks. He tells you he has had many sexual partners and lost time because of frequent daily masturbation or seeking new partners. He looks depressed. Do you feel he has HD?

**Competing interests** None.

**Provenance and peer review** Commissioned; externally peer reviewed.

Accepted 21 February 2011

**Sex Transm Infect** 2011;87:370–371. doi:10.1136/sti.2010.047779

**REFERENCES**


How to recognise sexual addiction in the sexual health clinic setting?

David Goldmeier and Jenny Petrak

Sex Transm Infect 2011 87: 370-371
doi: 10.1136/sti.2010.047779

Updated information and services can be found at:
http://sti.bmj.com/content/87/5/370.full.html

These include:

References
This article cites 7 articles, 2 of which can be accessed free at:
http://sti.bmj.com/content/87/5/370.full.html#ref-list-1

Article cited in:
http://sti.bmj.com/content/87/5/370.full.html#related-urls

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/