

Hypersexual Disorder - A Case Report and Analysis

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ABSTRACT

The concept of hypersexuality or Hypersexual Disorder (HD) has been around for some time but has been mostly bracketed within the category or as a symptom of bipolar mania. Controversy surrounds however the true place of hypersexual disorders amongst the various disorders in both the Diagnostic & Statistical Manual (DSM) and the International Classification of Diseases (ICD). Clinical practice and shared opinion would suggest that it may belong in the category of Mood Disorders, Impulse Control Disorders, Paraphilic Disorders or even Obsessive-Compulsive Disorders. The aim of this article is to shed light on hypersexual disorder as an entity separate and apart from the realm of a comorbid psychiatric illness and present it as a psychiatric phenomenon capable of causing significant psychological and social distress to patients suffering this disorder.

Introduction

Hypersexual Disorder (HD) is defined as “stronger than usual urge to have sexual activity”. It is most commonly associated with either bipolar mania or paraphilic disorders however a number of clinicians and researchers have suggested that it may exist as a distinct psychopathological condition. Efforts were made to include it as a distinct entity in the DSM most notably by Kafka who proposed specific criteria to include repetitive engagement in sexual fantasies, urges and behavior, unsuccessful efforts to control them and disregard of risk to physical or emotional harm to self or others (see DSM-5). However, lack of validation by scientific data and the use of imprecise words (e.g. “frequent”, “repetitive” and “great”) have prevented the incorporation of this criterion into the DSM-5. Nonetheless, the inclusion of “hypersexual disorders” criteria in DSM-5 would have provided clinicians a reference and help them to recognize this disorder as a separate entity.

Etiology & Pathogenesis

Different pathophysiological models have been proposed for conceptualizing the etiology of hypersexual disorder [1]. These include a sexual dysregulation model, sexual addiction and dependency model and sexual compulsivity and impulsivity models [2]. Sexual dysregulation model theorizes that sexual dysfunction or changes in desire may stem from early onset sexual abuse in childhood or experiences that shape future sexual behavior. Sexual addiction and dependency model focuses on persons who are unable to control their

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urges, thoughts and behavior as it relates to sex. In this model, sexual addiction is characterized as a brain disease. The sexual compulsivity and impulsivity model focuses on a tendency to experience increased sexual desire and activity during periods of depression or anxiety as a way to cope. Little is known about the brain pathways and neurotransmitters implicated in this disorder however dopamine, serotonin and androgenic hormones appear to play a critical role.

Case Presentation

Ms. R is a 40-year-old self-employed female with a diagnosis of Bipolar I disorder for greater than 10 years. She is currently divorced and of a Jehovah Witness religious affiliation. She has been previously admitted to a psychiatric facility and maintained on quetiapine and valproic acid. Her presentation to the psychiatric department is usually characterized by excessive speech, tangentiality, flight of ideas and severe social disinhibition. On questioning she would reveal without any discretion, intricate details of her sexual escapades. For instance, on one occasion while walking on the road she met a security guard and proceeded to have unprotected sexual intercourse with him with the intention of getting pregnant for this unknown male. One of her most recent sexual behaviour included engaging in group sexual intercourse with two brothers at a nude beach.

Ms. R's past has been characterized since age 17 by poor social functioning. She has a history of changing boyfriends yearly and has been attempting to conceive and deliver. She is a naturalized citizen of the United States and her desire for sex leads her in that direction for at least 6 months out of the year. Her frequent unprotected sexual intercourse has resulted in 5 pregnancies out of which 3 have been stillbirth and 1 has been a spontaneous miscarriage. Ms. R is currently a mother of a son who is 8 years old. Her psychosexual history is noted for sexual molestation by 2 brothers when she had to go to the United States for basic military training. Subsequent to the molestation she was asked to leave the training with an intention to seek counseling.

Ms. R was brought up in a highly strict and religious environment which was dominated by her Christian father. Having regularly attended church and being raised in an authoritarian setting may have resulted in a constant conflict between her id and the ego and a desire to please her highly demanding father.

Ms. R's desire for sexual activity is so intense that she has reported feelings of anxiety and distress upon seeing her monthly menses which serve her as a reminder of her "infertility" and that her "eggs are dying". Her hospital stays in the psychiatric ward have been marked by her attempts to initiate sexual contact with co male patients resulting in 24-hour intensive monitoring by nursing staff. A strict protocol has been taken trying to separate her from the male patients and reduction of her bathroom privileges in an attempt to curb her sexual promiscuity.

It has been interesting to note that Ms. R's hypersexual behavior has not always been associated with her manic episodes. Her hyper sexuality is not a manifestation of underlying ICD, OCD or a paraphilic disorder. Ms. R has also had a complete diagnostic work up to rule out any underlying organic conditions including a blood count, complete biochemical profile, thyroid and renal function testing along with brain imaging with a CT scan which have all been negative. She has engaged in multiple sexual risks taking behavior and upon subsequent review by her psychologist did not display any other features of mania such as pressured speech, distractibility, decreased need for sleep or flight of ideas. Unfortunately, each time she is brought to the local psychiatric facility, the psychiatrists have attributed her compulsive sexual behavior to her mania and used it as evidence to say that she is decompensating.

Discussion

Hyper sexuality is increasingly becoming a topic of increased research [3]. It has received considerable media coverage both in print and social media especially due to numerous cases of celebrity involvement. The celebrities who have battled with sex addictions are endless. These individuals have not been thus far diagnosed with a primary psychiatric or organic

disorder to which their behavior can be attributed to. This opens the door to a deeper look into sexual urges and whether they really can occur independently of any psychopathology.

The Caribbean populace holds clear notions about sexual activity and the amount of sexual activity that is appropriate. Some persons hold clear notions that repressing sexual urges causes headaches and mental stress [4]. Frequent sex is viewed as a form of vitality and potency and there is great pressure among the adolescent groups to initiate relationships and sexual activity [4]. A great deal of sexual activity in the Caribbean takes place outside of a marital union and described as “casual” [5]. Little is known about multiple sexual relationships among Caribbean women however common practice dictates that women to engage in multiple relationships. The extent of current practice may not be as high as in men however does exist to some degree. Portrayal of sex in the media in the form of rowdy lyrics is also common practice which has been theorized to increase sexual activity with multiple partners [4].

Investigations such as the Jamaican Youth Risk Resiliency Survey have indicated that both girls and boys are experiencing first coitus at earlier ages than some 10 years ago. Many other studies have found similar trends of early experimentation, and multiple partnering (serial and concurrent) in the Caribbean among adolescents and adults. So, we are all having sex, because we all enjoy sex, it feels good to adolescents and adults alike and we are having sex in greater proportions than all other mammals and there is a clear and substantive reason why.

As such, it is difficult to categorize the index patient's case as a disorder given the circumstances and sexual culture that is prevalent throughout the Caribbean. The sexual addiction and dependency model along with sexual compulsivity and impulsivity allow us to differentiate our patient's sexual practices from societal norms which exist in the Caribbean. Sexual addiction diminishes the capacity to control sexual desire that persists without fear of harmful consequences. In Ms. R's case, her sexual escapades serve as a coping

mechanism to deal with painful affects, especially shame to early strict upbringing by her father; however, this coping results in loss of control in spite of negative consequences. Like drug use, sexual arousal induces pleasant states, euphoria and relieves stress in the initial phase but afterwards causes dependence, craving and frequent relapse. Sexual addiction in the case of Ms. R may be from an underlying addictive personality and sex just happens to be the current medium that manifests it.

Our patient displayed no evidence of being influenced by peer pressure or faulty cognitions surrounding lack of sex and physical symptoms which precipitated her frequent desire for sex. Ms. R continued her sex escapades during period of mood stability and euthymia with no evidence of decompensation in sexual behavior during periods of depression and anxiety. She also denied recurrent / obsessive thoughts suggestive of OCD.

Clinical Implications

Identifying hyper sexuality as a symptom can be a diagnostic challenge for the clinician. Patients may not be forthcoming discussing a particularly sensitive topic such as their sexual practices even if adequate rapport has been built. A physical sign such as genital trauma does not prove the presence of compulsive sexual behaviors. Consequences of these behaviors are not limited to higher risk for sexually transmitted diseases (STDs) and physical injuries due to sexual practices in unsafe environments [1]. Another significant consequence is loss of time and productivity. Financial losses can mount quickly and patients can have innumerable admissions to psychiatric facilities especially if they have a primary psychiatric disorder such as Bipolar Disorder (BPD). In addition, there is a long list of legal consequences and the effects on family and interpersonal relationships can be profound. Thus, it is extremely critical in the author's opinion to sensitize the medical community to be on the lookout for hypersexual disorder as a distinct phenomenon, one that needs considerable support from the community to prevent societal breakdown. Treatment of hypersexual disorder

may include cognitive behavior therapy, psychodynamic therapy, 12-step approach or pharmaceutical management.

Conclusion

Hypersexual disorder may be considered an independent and does not always need to be combined or viewed as associated with another primary psychiatric disorder. Clinicians should be sensitized to its existence which would possibly prevent stigmatization and incorrect classifications of this population.

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