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A Guide to AIDS Research and Counseling

Sexual Compulsivity and HIV: Identification and Treatment

Frederick Muench, PhD and Jeffrey T. Parsons, PhD

Sexual compulsivity, also known as "compulsive sexual behavior" or "sexual addiction," is a clinical phenomenon characterized by sexual fantasies and behaviors that increase in frequency and intensity sufficiently to interfere with personal, interpersonal, or vocational pursuits. Although it has been suggested that the concept of sexual compulsivity was "created" as a way of limiting individual freedom to experiment sexually, over the past 10 years, a growing literature base suggests that sexual compulsivity represents a discrete clinical problem with a clear onset and course.[1–4]

Most notably, several investigations have cited a robust relationship between sexual compulsivity and HIV-related risk behaviors. This article defines sexual compulsivity, its etiology, and its consequences, particularly as they relate to HIV-related risk. It also presents approaches to assessment and treatment options.

There is limited epidemiological data on sexual compulsivity, perhaps because it is defined in so many ways. However, researchers estimate that sexual compulsivity exists in 3 percent to 6 percent of the total adult U.S. population and in significantly more men than women.[1] It also appears that rates of sexual compulsivity are significantly higher among gay and bisexual men.

Sexual compulsivity differs from "paraphilias," which are socially deviant expressions of sexual behavior such as voyeurism or pedophilia. Sexual compulsivity is characterized by exaggerated expressions of a range of sexual behaviors such as compulsive masturbation, excessive use of pornography, sex with multiple anonymous partners, excessive use of the Internet for sexual purposes, and disproportionate amounts of time thinking about sex or obsessing about a particular sexual partner.[2–4]

There is also limited research on how sexual compulsivity manifests among different subpopulations, however, most people with sexual compulsivity report strong urges for sex, preoccupation with sexual thoughts, loss of control over sexual activity, and spending disproportionate amounts of time engaged in sexual thoughts and behavior. They also report significant adverse consequences as a result of excessive sexual thoughts and activity, including: interpersonal conflict and distress; social and occupational problems resulting from lack of time to participate in non-sexual activities; psychological distress, especially regarding self-esteem; and financial problems resulting from the costs of pornography, paying for sex, and loss of income from avoiding work responsibilities. Finally, people with sexual compulsivity face physical consequences such as increased risk for HIV and other sexually transmitted infections that threaten health.

While other sexual disorders are listed in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), there is no classification for sexual compulsivity except under "Sexual Disorders, Not Otherwise Specified." Sexual compulsivity has been conceptualized as an addiction, an obsessive-compulsive spectrum disorder, an affect disorder, and an impulse control disorder.[3,4] One consequence of the lack of a specific classification is that there are a limited number of reliable and valid assessment tools and interventions for sexual compulsivity.

Symptoms and Clinical Correlates

People with sexual compulsivity have extremely high rates of comorbidity with other psychological disorders—rates similar to people entering outpatient treatments for other disorders. Across studies,

Editorial: Impulsive Risk Reduction

Robert Marks, Editor

The context in which people make decisions about sexual risk reduction varies along a broad spectrum. For some it is a process of thoughtful reflection outside the heat of the moment; for others, it is almost an afterthought, an impulse, during the dash toward satisfying sexual desire. While most HIV prevention providers promote approaches on the more contemplative end of this scale, what happens when an aspect of a person's psychology makes the deliberative process impossible?

The articles in this issue of *FOCUS* look at two examples of this dynamic. Frederick Muench and Jeffrey Parsons present an overview of sexual compulsivity, defining its relation to HIV-related risk, assessment, and treatment. In her article on the connection between Viagra use and HIV, Lisa Loeb describes the relationship among HIV-related risk, Viagra, and methamphetamine, which elevates the desire for, and frequency of, sex.

While the research literature on HIV and both sexual compulsivity and Viagra is nascent, so far the evidence supports a common sense conclusion: these behaviors interfere with the ability to reflect on or to carry out decisions about risk and, in doing so, they undermine many approaches to risk reduction.

It is crucial at this point for both research and intervention program planning to avoid sensationalizing or criminalizing these behaviors. There is a wide range of behavior that may be construed as sexually compulsive, but every individual is different and each behavior taken alone does not necessarily rise to the level of a psychiatric condition.

When sexual compulsivity is diagnosed or when substance use rises to the level of a disorder, treatment can control these conditions. Further, harm reduction can mitigate the most dangerous effects of these behaviors both for people who are sexually compulsive and for those who use Viagra (and for their sexual partners).

Implementing any of a range of approaches, however, requires helping people explore ingrained and stigmatized behaviors. To reduce stigma, it is necessary to educate the public and policy makers about these behaviors and their risks. To control the uninformed or inappropriate use of drugs like Viagra, it is important to advocate for the reform of the rules that govern pharmaceutical marketing, which may entail a long, hard, struggle.

Full disclosure: AHP has just completed an analysis of data from HIV testing clients on the relationship between Viagra use and HIV risk. We are planning to develop written materials to educate gay and bisexual men about the dangers of Viagra use, in particular, in combination with methamphetamine. AHP has received an unrestricted charitable contribution from Pfizer, Inc. the maker of Viagra.

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rates of psychological disorders other than personality disorders—in particular, mood disorders, anxiety disorders, and substance use disorders—ranged from 64 percent to 81 percent.[1,4,5] In two of these studies, rates of personality disorders ranged from 41 percent to 46 percent.[1,4] Some authors argue that sexual compulsivity is a manifestation of other disorders such as bipolar disorder or personality disorders, especially borderline personality disorder. But the fact that no one cluster of other disorders appears to be associated more often with sexual compulsivity suggests that this condition represents a distinct clinical phenomenon.

Other symptoms associated with sexual compulsivity are low self-esteem, social anxiety, loneliness, intimacy problems, social skills impairment, guilt, sensation seeking, and additional impulse control problems. It is notable that rates of childhood sexual abuse among people with sexual compulsivity range from 30 percent to 78 percent,[1,2,6] suggesting that this experience is an important factor.

Sexual Compulsivity and HIV Risk

People who score higher on measures of sexual compulsivity are significantly more likely to engage in unprotected sexual behaviors. This relationship, which has been examined primarily in samples of HIV-positive people and men who have sex with men, is extremely robust, that is, it is well supported by statistical analysis.

For example, a study of 294 HIV-positive men and women found that those who scored high on a measure of sexual compulsivity reported more acts of unprotected vaginal and anal intercourse with partners who were HIV-negative or of unknown HIV status than did those who scored low on this sexual compulsivity scale.[7] In another study of 223 HIV-positive men participating in substance abuse treatment groups and HIV prevention programs, higher sexual compulsivity scores were associated with higher rates of unprotected sex with multiple partners.[8]

Men who have sex with men have been the focus of several investigations of sexual compulsivity, despite the lack of data docu-

People who score higher on measures of sexual compulsivity are significantly more likely to engage in unprotected sexual behaviors.

menting that this group experiences sexual compulsivity at greater rates than other men. In a study of men who have sex with men seeking care for addiction or sexual risk, 31 percent of the sample reported being sexually compulsive.[6] Another study of HIV-positive men who have sex with men found that those with higher levels of sexual compulsivity were more likely than others to engage in unprotected sex and less likely to disclose their serostatus to sexual partners.[9]

Finally, in Project SPIN, a study of 183 gay and bisexual men reporting difficulties controlling their sexual behavior, 25 percent were HIV-positive, 75 percent had had at least one sexually transmitted disease in their lifetime, and 50 percent had more than one STD. In this skewed sample of men, all of whom reported out-of-control sexual behavior, higher sexual compulsivity scores were still associated with greater numbers of unprotected anal sex acts.[5]

There are several reasons why sexual compulsivity may be related with HIV risk. First, sexual compulsivity is associated with higher numbers of sexual partners, a significant factor for acquiring HIV. Compared to a broader sample of gay and bisexual men, men in Project SPIN reported significantly more sexual partners (39 versus 7) in the previous 90 days.[5] Second, loss of control over sexual behavior can lead directly to HIV-related risks. For example, in Project SPIN, 74 percent of the men specifically attributed their recent unprotected anal sex to their sexual compulsivity.[5]

Third, the interrelationship between sexual compulsivity and substance use may increase HIV-related risk.[10] Fourth, over time, an acclimatization or "tolerance" may occur, in which people with sexual compulsivity could potentially put themselves at greater risk in order to increase their sexual repertoire. Fifth, people with sexual compulsivity may be more likely to engage in sexual encounters with other sexually compulsive individuals. In one study of men who have sex with men, those with higher sexual compulsivity scores were more likely to find their partners in cruising areas and public sex venues than those with lower scores. It is notable that these venues also attracted more HIV-positive men who have sex with men.[6]

Assessing Sexual Compulsivity

Knowledge about sexual compulsivity has yet to be integrated widely into clinical settings. In addition, because comorbidity rates are so high among those with sexual compulsivity, people may seek treatment for associated features such as childhood sexual abuse, depression, or substance abuse. Sexual compulsivity often goes unrecognized in these settings for several reasons, including: limited understanding of the problem and its chronic course; mistaking sexual compulsivity for an associated feature of another disorder; social stigma regarding the behavior, which leads to limited self-disclosure; awkwardness among both clients and providers regarding the topic; lack of resources to publicize the problem; limited dissemination of research; and most importantly, the lack of diagnostic classification in the DSM.

While these issues continue to pose a problem, several instruments can reliably discriminate between people who have trouble controlling their sexual behavior and those who do not. Based on the measures, the most important questions to ask when assessing sexual compulsivity are:

- How many sexual partners have you had in the prior year?
- Do you have difficulty controlling your sexual thoughts and behaviors?
- How much time do you spend engaged in sexual thoughts and behavior?
- Do you feel unable to resist acting on your sexual urges?
- Do you feel distressed, guilty, or shameful about your sexual thoughts and behavior?
- What have been the consequences of your sexual thoughts and behavior?
- Do you feel you have engaged in risky sexual encounters because of the drive to have sex?

In general, if a person answers that they have difficulty controlling sexual behavior, are unable to resist sexual urges, spend excessive time in sexual behaviors, and experience significant consequences or internal distress as a result of their sexual thoughts and behavior, it is likely that he or she suffers from sexual compulsivity. The other questions regarding number of sexual partners and engagement in risky sexual activities help the clinician gauge

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the extent to which a person's sexual compulsivity puts him or her at risk for STDs.

Sexual Compulsivity Treatment

There is an extremely limited empirical literature treatment for sexual compulsivity and no published controlled trials on the efficacy of either behavioral treatments or pharmacotherapy for sexual compulsivity. The greatest amount of empirical data has been derived from open label medication trials. Several of these trials have indicated that selective serotonin re-uptake inhibitor (SSRI) antidepressants such as Prozac, Zoloft, and Luvox are effective in reducing the spectrum of compulsive sexual thoughts and behaviors.[11] It appears that the remedial effects of SSRIs occur whether or not the drug causes sexual side effects and no matter how effective it is in treating depression; they work primarily by reducing excessive sexual urges and fantasies.

Psychotherapeutic treatments for sexual compulsivity vary greatly in emphasis. They extend from psychodynamic therapies that focus on the intense sexual transference of the client to therapist, to cognitive-behavioral therapies that focus on interpersonal skills, self-monitoring, behavioral contracting, and relapse prevention.

Regardless of intervention type, most treatments target the clinical correlates of the behavior, for example, loneliness, isolation, shame, intimacy problems, childhood sexual abuse, anxiety management, and depression, as well as loss of control over sexual thoughts and behaviors. Most interventions seek to have clients define their own treatment plans and attempt to foster non-sexual interpersonal relationships as well as a healthy sense of sexuality. Several treatments also suggest that individuals attempt a period of "sexual sobriety" prior to creating individualized plans.

Patrick Carnes, who initiated the treatment of sexual addiction more than 20 years ago, advocates an integrated model of psychotherapy, with a primary focus on 12-step theory.[2] Each of five sexual compulsivity 12-step groups differs in terms of what it labels "sexual sobriety": definitions range from complete abstinence from all sexual behaviors until the individual can enter a committed relationship, to individual sexual recovery plans in which a person identifies his or her own sexual boundaries.

Since sexual compulsivity can have many manifestations and is likely to be resistant to simple therapies, interventions should be individualized to each client's needs and include various modes of behavioral and psychopharmacological treatments.[3] For example, individuals in the early stages of treatment may not be able to tolerate group settings where the temptation to act out sexually may be too overwhelming. Treatments may also vary depending on the population treated. For example, people in relationships may be best served in couples therapy in order to build trust and establish healthier sexual relations between partners. Treatments targeted towards gay and bisexual men have focused on managing societal and internalized homophobia, re-evaluating sexual norms, and reducing HIV risk behaviors. Most treatment for sexual compulsivity invariably includes some form of HIV risk reduction.

Conclusions

In addition to the distress experienced by people with sexual compulsivity, the association between sexual compulsivity and HIV transmission clearly indicates that this problem warrants significant attention. Treating those suffering from out of control sexual behavior can greatly reduce the number of new HIV infections, especially among men who have sex with men. While implementing proper assessment and identification is the first step, learning more about community resources for this problem and integrating intervention techniques for sexual compulsivity into clinical repertoires will help providers best respond to clients facing this challenge.

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Viagra: The Science and Politics of Drugs, Sex, and Risk

Lisa Loeb, MPH

An advertisement in the *New York Times* recently offered me a sample of "Free Viagra." A stranger at a party last month offered my client Viagra in exchange for sex. Spam e-mails routinely offer all of us Viagra for purchase without a prescription, and television ads for the drug fill the airwaves. Viagra's presence has become unavoidable. Why does Viagra use seem so common? What harm might come from recreational use of this relatively new medication? What does Viagra have to do with HIV?

Like the oral contraceptive ("the pill") before it, sildenafil citrate (the generic name for Viagra) is a medical treatment that has sparked a sexual revolution of sorts. This "little blue pill," is marketed by its manufacturer, Pfizer, Inc., as an agent of personal freedom for men; and indeed, it has helped millions of men who suffer from impotence. But it is also used casually as a "lifestyle drug" to achieve non-medical goals, and it is widely available on the street. It is important for Viagra users to know about the risks of recreational use of sildenafil citrate, including adverse interactions with HIV medications, heart attack, and increased risk for acquiring HIV and other sexually transmitted diseases (STDs).

Causes of Impotence

The term "impotence" includes the inability to have an erection firm enough for sexual intercourse, as well as problems with orgasm, ejaculation, and even sexual desire. Complete inability to achieve erection is uncommon, ranging from 5 percent at age 40 to 15 percent at age 70 among men in the United States.[1] Complications from diseases such as diabetes, hypertension, alcoholism, and HIV cause most cases of impotence; injury, side effects from medications, and psychological complications are also common causes.

HIV antiviral treatment has enabled many HIV-positive people to feel well enough to rekindle their sex lives, but an estimated 25 percent of HIV-positive men report problems achieving erection. It remains unclear whether HIV treatment or HIV disease causes this dysfunction, however, it is clear that men with HIV commonly report using impotence medications.[2]

Treating Impotence

Treatments for impotence include physical devices (vacuum pumps, rubber constricting rings), penile injections, surgery, psychotherapy, or a combination of these approaches. In 1998, Pfizer launched the first pharmaceutical treatment, Viagra, along with the phrase "erectile dysfunction" to replace the stigmatized medical diagnosis of impotence. Recently, other manufacturers have released similar drugs such as tadalafil (Cialis) and vardenafil (Levitra). All three drugs promote erections by increasing blood flow into the penis: by inhibiting an enzyme (phosphodiesterase type 5), they lead to vasodilation (widening of blood vessels) in the pelvis. None of these drugs can overcome a complete inability to have an erection.

Viagra use is common: Pfizer reports that 16 million men have used it, and nine pills are purchased each second across the globe. Tadalafil may soon be just as common: it lasts about 36 hours, rather than Viagra's four, thus its nickname "the weekender." Vardenafil may be more effective than Viagra or tadalafil in men with co-occuring diseases such as diabetes or prostate cancer.

Although these drugs were developed to treat a clinical condition, doctors are now prescribing them to improve sexual functioning in the absence of diagnosed impotence. These medications are being used "by the guy who needs a little help now and then" to overcome performance anxiety, to achieve a harder erection than he is normally capable of, and even to enhance his self-esteem. Like other recreational drugs, impotence drugs are traded among friends at parties and purchased from dealers in dance clubs. It would seem easy to

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See also references cited in articles in this issue.

make a case that these medications are being abused both by doctors, who prescribe them as lifestyle drugs, and by consumers, who buy them on the Internet through unregulated and faceless "electronic pharmacies."

Who Uses Viagra?

Although men of all sexual orientations and behavioral risk populations use impotence drugs, current studies of recreational Viagra use have focused on men who have sex with men. Among them, self-reported rates of Viagra use can be as high as 42 percent (see table, page 7, Viagra Use among Men Who Have Sex with Men). In particular, men who present at STD clinics, men who have unprotected anal sex with male partners of unknown serostatus, and men who attend circuit parties all used Viagra at elevated rates.

While HIV-positive men may use Viagra to overcome HIV-related impotence, even HIV-negative men who have sex with men report using Viagra to improve their sexual "lifestyle." For example, impotence drugs can facilitate insertive anal intercourse, which requires a highly rigid penis (more so than vaginal or oral sex). Since impotence drugs decrease the refractory period (recovery time required after ejaculation before a subsequent erection), they can also multiply the number of potential ejaculations in a given time. In group sex settings, where peer pressure to perform may be magnified, men may take impotence drugs to generate a visibly hard erection or to facilitate having multiple partners over a short period.

The Speed Connection

Methamphetamine, a common stimulant, leads to increased sexual drive, increased physical stamina, and behavioral disinhibition. It elevates motivation for sex, potential duration and frequency of sex, and the likelihood that sex will occur if the possibility arises. Further, methamphetamine use can alter decision-making capacities, hampering users' abilities to negotiate with partners or implement risk reduction plans.

At the same time, methamphetamine can induce impotence, also known as "crystal dick." Methamphetamine acts as a "vasoconstrictor" (narrowing blood vessels, increasing blood pressure, sending blood to the extremities) while Viagra and other impotence drugs act as "vasodilators" (opening blood vessels, lowering blood pressure, sending blood to the pelvis). In other words, methamphetamine use decreases blood flow to the penis, and Viagra compensates for this by increasing blood flow to the penis.

Some men take Viagra to overcome crystal dick. The combination of methamphetamine—which leads to increased desire and stamina—and Viagra—which facilitates this frequent and ongoing sexual activity—is a potent elixir for HIV and STD transmission in the absence of condom use or negotiated safety. More sex means more opportunities for exposure to HIV and increased susceptibility to infection in the event of exposure. For example, increased duration and frequency of sex can lead to a greater likelihood of abrasions on the penis, a potential port of entry for HIV.

Manufacturing Desire

Two years after its introduction, Pfizer had embedded Viagra in popular culture, offering free diagnostic screening and referral for prescriptions everywhere from NASCAR to soul concerts. In the first year of marketing, patient demand for the drug, rather than physician-diagnosed impotence,* was a significant factor in Viagra's sales. After spending $185 million on marketing, Pfizer sold $1.7 billion worth of Viagra in 2002.

Viagra's extraordinary marketing success has spawned an industry that may disturb even the drug maker. Impotence drugs can be readily purchased on the Internet without a prescription (a single dose of Viagra costs about $25.00). A recent study estimated that between 4,500 and 15,000 web sites advertise Viagra for sale, and approximately 150 distinct companies (none of them Pfizer) behind these sites sell more than 1,000 prescriptions a day.[4]

Today 57,200 sites sell Viagra, most requiring buyers to fill out a "patient questionnaire" in lieu of a doctor's prescription. Providing a prescription drug without a valid prescription is illegal, but these rogue companies are skilled at evading the U.S. Food and Drug Administration's (FDA) limited number of investigators. Among the risks these sites pose are the sale of contaminated, expired or even counterfeit drugs, and the provision of drug combinations that can result in life-threatening interactions (such as Viagra with

*In other marketing news: Pfizer has conducted research into a female market for Viagra and has coined the term "female sexual arousal disorder" as the condition it would treat. This has been called "the freshest, clearest example" of corporate-sponsored creation of a disease.[3] And Wrigley, the maker of Doublemint gum, has applied for a patent for Viagra chewing gum.

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Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

isosorbides, drugs used to treat certain heart problems).

Viagra and HIV Acquisition

Beyond the risks of Internet purchasing, there are more serious risks for users of impotence drugs. In several studies, researchers have found statistically significant associations between Viagra use and HIV and STD acquisition. In a study of more than 7,000 male clients of an anonymous HIV test site, men who had used Viagra in the prior year were almost four times more likely than non-users to have recently seroconverted.[5] While this study included men of all sexual orientations and risk behaviors, all the seroconversions were among men who have sex with men.

Another study, this time of HIV-positive men who have sex with men, found that 50 percent of a sample of Viagra users attending an STD clinic had a current STD, compared with only 26 percent of non-users.[6] A third study found that men who have sex with men and used both Viagra and methamphetamine were 6.1 times more likely to have syphilis than men who did not use either drug.[7] Finally, a Centers for Disease Control study found that men who have sex with men and who used Viagra were 6.5 times more likely to engage in unprotected insertive anal intercourse than those who did not.[8]

Viagra Use among Men Who Have Sex with Men

Group Studied	Sample Size	Percent Using Viagra*
STD clinic patients[6] (all sexual orientations)	352	31% (prior year)
HIV-positive STD clinic patients	67	39% (prior year)
HIV-negative STD clinic patients	226	29% (prior year)
Circuit party attendees[10]	295	14% (prior out-of-town party)
Men in an anonymous street-based survey[2]	837	32% (ever) 21% (prior 6 mos.)
HIV-positive men	104	42% (prior 6 mos.)
HIV-negative men	657	19% (prior 6 mos.)
Men of any serostatus who had unprotected anal intercourse with a partner of unknown serostatus	70	37% (prior 6 mos.)
Men seeking anonymous HIV testing[5]	3,114	10% (ever) 8% (prior 6 mos.)

* (in parentheses) = Time period in which Viagra was used.

It's a Prescription Drug—Isn't It Safe?

In response to the potential for increased rates of HIV or STD acquisition or transmission among Viagra users, public health officials have attempted to inform users about these risks by lobbying Pfizer and the FDA. To date, there is no HIV or STD information on Viagra packaging and no public education campaign about HIV-related risks. Thus, front-line health care and mental health providers may become an essential source of information about these risks.

It is important to note that impotence drugs may cause health problems in addition to elevated HIV risk. The combination of impotence drugs plus nitrates—including both recreational inhalants such as "poppers" and medications such as nitroglycerin for treatment of angina—can cause a life-threatening drop in blood pressure. Certain impotence drugs absolutely should not be used by men on alpha-blocker therapy (treatment for hypertension and certain prostate conditions).

There have also been reports of priapism, a painful and serious condition characterized by a persistent erection of more than four hours duration, among Viagra users. Priapism is a medical emergency, since it can lead to permanent damage to the penis. Finally, impotence drugs in combination with protease inhibitors, in particular, ritonavir or indinavir, can lead to a severe drop in blood pressure, and may alter blood levels of the protease inhibitors.[9]

Conclusion

Viagra, a revolutionary medical treatment, a key source of revenue for one company, and a constant presence in our e-mail inboxes is now a "lifestyle drug." It enables sexual intercourse that would otherwise not occur, both among men with diagnosed impotence and among otherwise healthy men who want to enhance their sexual pleasure. People at risk for contracting or transmitting HIV through sex, particularly some men who have sex with men, may increase their HIV risk by using impotence drugs. Men who use Viagra and methamphetamine are at extreme risk for HIV infection and urgently need specific HIV prevention messages. Still, eliminating Viagra use may be an unreasonable goal. Instead, health and mental health providers—including HIV antibody test counselors—might consider educating clients, particularly those who also use methamphetamine, about the risks of Viagra use and ways to reduce these risks and potential harms.

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Recent Reports

Overview of Compulsive Sexual Behavior

Coleman E, Raymond N, McBean A. Assessment and treatment of compulsive sexual behavior. *Minnesota Medicine.* 2003; 86(7): 42–47. (University of Minnesota, Minneapolis.)

The dividing line between normal sexual expression and compulsive sexual behavior is not as clear as it might seem, according to an overview of the condition. Many people experience problematic sexual behavior that simply reflects human fallibility—including mistakes, errors in judgment, and transgressions against their own values or societal norms—rather than clinical pathology.

Diagnosing compulsive sexual behavior, which is classified as "nonparaphilic," when it involves conventional sexual behavior, or "paraphilic," when it involves unconventional sexual behavior such as pedophilia, exhibitionism, and voyeurism, requires careful assessment. The seven types of non-paraphilic compulsive sexual behavior are: cruising and multiple partners; fixation on an unattainable partner; autoeroticism; use of erotica; compulsive use of the Internet; multiple love relationships; and compulsive sexuality in a relationship.

All types involve obsessive behavior, such as frequent sexual self-stimulation, excessive Internet surfing for sexual gratification, and constant scanning for potential partners. Many involve an "intrusion into reality" such as ritualistic or trance-inducing cruising, idealization of the love object, and fantasy and role playing in multiple love relationships.

Treating Compulsive Sex with Naltrexone

Raymond NC, Grant JE, Kim SW, et al. Treatment of compulsive sexual behaviour with naltrexone and serotonin reuptake inhibitors: Two case studies. *International Clinical Psychopharmacology.* 2002; 17(4): 201–205. (University of Minnesota, Minneapolis.)

Two case studies indicate that naltrexone, when taken with selective serotonin reuptake inhibitors (SSRIs), can effectively treat patients with compulsive sexual behavior.

Naltrexone is commonly used to treat disorders associated with urges. While not all patients experience positive results with this treatment, two cases suggest that naltrexone, used with SSRIs, can treat symptoms of compulsive sexual behavior in some patients.

A 42-year-old woman reported problems with frequent sexual activity with multiple partners outside her marriage. She experienced suicidal ideation and despair related to lack of control over her sexual behavior, had recently stopped regular cocaine use, and was diagnosed with major depression.

For two months, the woman took 60 milligrams of the SSRI fluoxetine, which improved her anxiety and depression. She continued to report daily sexual and cocaine-related urges, however, and engaged in extramarital sex about every two weeks. The woman then began taking 50 milligrams of naltrexone daily in addition to the fluoxetine, and after increasing to 100 milligrams of naltrexone, she reported an almost complete remission of both sexual and cocaine-related urges, which continued for eight months.

During a transition to citalopram, a different antidepressant, the woman noticed an increase in sexual urges, which disappeared after increasing naltrexone to 150 milligrams. She switched back to a lower dosage of fluoxetine and has since experienced positive results for one year.

A 62-year-old man reported a 20-year history of intermittent problems with compulsive sexual behavior, including extramarital affairs with co-workers and sex workers. After one month on a daily dose of 50 milligrams of naltrexone and 40 milligrams of citalopram, the man reported "unbelievable" results, and he was able to pursue other interests in the absence of obsessive/intrusive sexual thoughts.

After two months, the man reported increased sexual urges, and increased his naltrexone dosage to 100 milligrams. The man has remained on this regimen for eight months without recurrence of symptoms.

Next Issue

People often greet behavior change with ambivalence. Motivational interviewing, first developed for substance use treatment, is particularly effective at helping people understand and overcome this ambivalence. In the August issue of *FOCUS,* **Denise Walker, PhD,** Assistant Professor, and **Roger Roffman, DSW,** Professor, both at the University of Washington, review the literature on motivational interviewing and HIV, in terms of medication adherence and risk reduction, and outline the process and skills for undertaking it.

Also in the August issue, **Donald McVinney, MSW,** National Director of Education and Training at the Harm Reduction Coalition in New York, discusses the application of motivational interviewing to psychotherapy.

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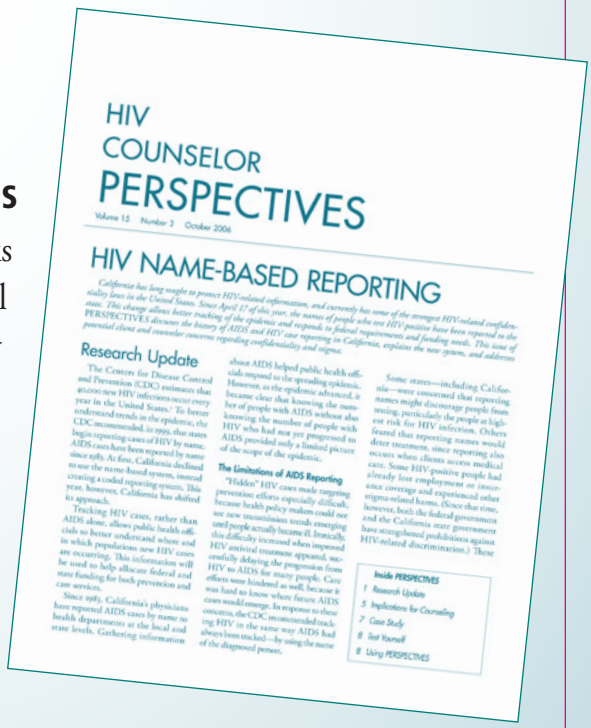
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