The management of hypersexuality in men

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Hypersexuality and its associates (sexual preoccupation and sexual compulsivity) may cause men who live with these disorders severe anxiety and distress. Moreover, hypersexuality is linked to deviant sexual interests, risky sexual behaviours and, potentially, criminal acts. In this article the author describes the nature of hypersexuality and how it can be managed.

Some people may manage their hypersexuality and feel comfortable with an elevated level of sexual urges, finding release through legal sexual outlets. Other people will struggle with this ‘monkey on their back’ and would benefit from medication and support to reduce the sexual urges that may feel overwhelming and pervasive in their lives. This article describes the various correlates of hypersexuality and outlines the types of medication available to help people who present with problematic sexual thoughts and/or behaviours. Other sources of support for hypersexuality are also presented, in particular for those who present with both hypersexuality and illegal sexual preferences (such as an attraction towards children).

DEFINITIONS OF HYPERSEXUALITY

Sexual preoccupation is used to describe an abnormally strong interest in sex – an interest that may be all-consuming, dominating a person’s waking moments. Non-sexual situations are perceived and interpreted as sexual, and the person may be distracted when simply talking to someone, eg spending their time focusing on the genitals or breasts of the person they are talking to, waiting for a glimpse of chest, the flash of a bra strap or some other sexually-feeding ‘view’.

Sexual preoccupation – or thinking about sex all the time, across almost all situations – is, unsurprisingly, linked to a high frequency of engaging in sexual behaviours; the latter is termed hypersexuality (or hypersexual disorder). Deciding if someone was hypersexual was originally done through assessing the number of orgasms a person reported having per week. However, a simple count of sexual activity was not considered sufficient to demonstrate abnormal behaviour, or pathology, unless it was also accompanied by solitary or impersonal sexual behaviour, such as masturbation or sex with prostitutes. Thus, it was not merely the number of times someone engaged in sexual behaviour leading to orgasm that was important, but rather about quantity, together with a lack of intimacy in sexual expression. Later definitions of hypersexuality (or hypersexual...
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disorder) linked sexual preoccupation, the seeking of sexual outlets and an increase in sexual fantasies, along with increases in sexual behaviours. So, in a sense, there is a ‘turning up’ of the sexual volume across a range of dimensions.

Additional terms for the landscape of hypersexuality are sexual compulsivity and sexual addiction. Sexual compulsivity can be understood as a recurrent, insistent, unwanted and intrusive urge to perform sexual acts, which may cause anxiety or distress, while the term ‘sexual addiction’ – which has variously been used as a synonym for both hypersexuality and sexual compulsivity – brings in the general addiction literature and is typically referred to as any sexual activity or urge that feels out of control.

It is evident that these terms broadly overlap and that hypersexuality is a convenient umbrella term for sexual thoughts, urges and behaviours that have become problematic for an individual.

HOW MIGHT INDIVIDUALS PRESENT WITH HYPERSEXUALITY?

There are four principal ways in which patients might present themselves to a GP or urology clinic. They may report physical symptoms, such as genital soreness from excessive masturbation; they may present with high levels of anxiety and/or obsessive/compulsive feelings underpinning their need for sex; their partner may have raised their excessive sexual needs as an issue in their relationship; and/or the person may wish to speak to a medical practitioner because they are concerned that their obsession with sex is out of control and they are worried that they may harm someone by committing an act of sexual abuse.

If presenting with the latter, the person will have already taken a first step in stopping themselves offending, and the medical practitioner will need to be encouraging, empathic, mindful of any reporting responsibilities as per their professional duties to report potential crimes, but also understand that the person has come to them for help.

WHAT IS NORMAL?

In their seminal study about human male sexual behaviour, Kinsey et al collected data from over 5000 males about their main sources of orgasm, the principal types reported by participants being masturbation, nocturnal emissions, petting and intercourse (heterosexual/homosexual), and intercourse with animals of other species. From their research, Kinsey et al reported that while there are some individuals who used one sole outlet for all their orgasms, most people regularly depended upon two or three sources, and some men reported having orgasms from all six sources within a short timeframe. The average frequency of orgasms (summed orgasms across all sexual outlets to give a ‘total sexual outlet score’ or TSO) was calculated as being 2.74 orgasms per week for the age group ‘adolescents to 30 years’, and 2.34 orgasms per week across the entire range of men (from adolescents to 85 years), taking into account differences in age, social status, religion and rural/urban area. At the high end of the distribution were men who reported regularly having seven or more orgasms per week (7.6%).

These early figures produced a baseline for high counts of sexual activity; however, even where someone reports having seven or more orgasms per week, this does not in itself indicate abnormality. Indeed, the data showing frequency of orgasms shows a smooth curve, not a wasteland between ‘normal’ and ‘abnormal’ frequencies of sexual activity. Usefully, however, Kinsey et al’s data gives us a cut-off figure – which is three times that of the average – as a starting point in considering if a person is presenting with hypersexuality.

KEY POINTS

- Hypersexuality can cause both physical and mental disorders; it may also contribute to risky, even illegal, sexual behaviours
- Medication can significantly reduce hypersexuality; patients may wish to seek psychological treatment while taking medication to unravel problems potentially underpinning the hypersexuality
- It is important that medical practitioners upskill themselves with regard to the use of medication to manage sexual arousal, and that they feel able and competent to prescribe or refer patients, as appropriate
- Medication does not have to be ‘forever’; constant monitoring of patients (including side-effects of medication) is important so that patients can reduce or stop medication as appropriate
- Patients taking medication to reduce hypersexuality report lower sexual arousal, greater emotional control and greater ‘headspace’ – all contributing to a better quality of life
- Prescribing medication to someone with hypersexuality could actually prevent sexual abuse (in some instances – not everyone presenting with hypersexuality will go on to commit a sexual crime)
- Practitioners should consider how they would manage a patient appointment in which the patient self-reports they are concerned that their hypersexuality may lead them to commit a sexual offence
THE IMPACT OF HYPERSEXUALITY
 Patients may report excessive masturbation (which can lead to soreness), overuse of cybersex and/or pornography, telephone sex, going to strip clubs, using prostitutes and other behaviours that may have financial, emotional and health-related costs. Hypersexuality may also cause distress and will typically have an adverse impact on relationships (either existing ones or inhibiting the forming of new ones), causing problems to a person's self-esteem as they struggle to cope with their sexual urges and feeling bad about not being able to do so. Patients may be anxious about their preoccupation with sex, which can be worsened further by any incongruence between the person's personal values (such as their religious or cultural beliefs) and their sexual urges.6

Time spent satisfying sexual needs may also impact upon a person’s home and work life with, for example, an individual finding it difficult to stop looking at internet pornography, neglecting their responsibilities elsewhere. There may also be a lack of emotion/anger control, with sufferers having ‘less headspace’ for dealing with life’s daily irritations. Moreover, hypersexuality may lead the individual to more extreme sexual excursions, with use of pornography becoming more aberrant and potentially ending with the viewing of illegal extreme pornography. This in turn may increase aggressiveness7 or lead to the hunting down of sexually explicit images of children.8

PHARMACOLOGICAL TREATMENT
 Pharmacological treatment may be particularly useful where individuals have come to feel that their hypersexuality is a burden. This may be an extrinsic burden, such as loss of personal freedom through incarceration following a sexual offence, or an intrinsic one, with the person reporting heightened levels of distress, anxiety and/or depression.

There are three main types of medication available to manage hypersexuality: selective serotonin-reuptake inhibitors (SSRIs), such as fluoxetine; anti-androgens, such as cyproterone acetate (CPA); and gonadotrophin-releasing hormone (GnRH) analogues, such as triptorelin. The mechanism of action and potential side-effects of each of these is outlined briefly below.

**SSRIs**
 SSRIs increase levels of serotonin in the neuronal synapses by blocking the transporter molecules that normally take serotonin back up into the presynaptic neurones, resulting in serotonin remaining in the synapses for longer. While SSRIs are typically used to treat depression, research has shown that they can also function as an anti-libidinal, since serotonin inhibits sexual desire, psychological and physiological arousal/erection and orgasm.9 Possible side-effects of SSRIs include nausea, insomnia, hypersomnia, anorexia and tremors.

**Anti-androgens**
 Anti-androgens directly reduce testosterone levels. While there are sizeable differences between individuals in testosterone levels – and thus a man’s testosterone level does not straightforwardly relate to the intensity of sexual thoughts, urges or behaviours, either deviant or non-deviant10 – the lowering of a person’s testosterone levels by approximately 30–40% will significantly reduce sexual arousal in a male.11 Anti-androgens, such as CPA, reduce testosterone levels below this threshold and thereby reduce hypersexuality. The effects of anti-androgens are considered to be reversible within one to two months following the stopping of medication. Possible side-effects include gynaecomastia, tiredness, depression of mood, osteoporosis and weakness.

**GnRH analogues**
 Triptorelin, a GnRH analogue, decreases pituitary secretion of the gonadotrophins luteinising hormone (LH) and follicle stimulating hormone (FSH). This in turn inhibits the production of testosterone by the testes. Possible side-effects include hot flushes, headaches and osteoporosis.

MANAGEMENT OF HYPERSEXUALITY
 Each of the above medications has been used to treat hypersexuality, although they may not be licensed specifically for this purpose. Few GPs will be approached by patients directly for help or medication for hypersexuality; instead, the plea may come from the disclosure of a deviant sexual interest in children, for example, or perhaps an obsession with pornography. With continuing pressure on NHS services, particularly non-mainstream specialist services, GPs and other secondary care doctors are likely to have an increasingly important role in helping and supporting individuals with problematic sexual thoughts and behaviours. It is therefore crucial that all healthcare professionals are aware, knowledgeable and comfortable about their vital place in helping people manage their hypersexuality.

In addition to medication, patients may also benefit from self-help groups, such as Sexual Addiction Anonymous, the support and treatment provided by charities such as the Midlands-based Safer Living Foundation, or through the Stop It Now national helplines run by the Lucy Faithfull Foundation (Box 1). Increasingly, charities are looking to provide services for people struggling with hypersexuality who may be concerned that they may offend sexually. Such individuals may need help with alcohol or drug problems, coping with trauma and/or cognitive behavioural therapy (CBT) to help them manage their intense sexual urges.

**Box 1. Sources of help and support for patients**

- Sex Addicts Anonymous (https://saa-recovery.org)
- Sex addiction and love addiction (NHS Choices) (http://www.nhs.uk/Livewell/addiction/Pages/Sexandloveaddiction.aspx)
- Stop It Now helpline (http://www.stopitnow.org.uk)
- Safer Living Foundation (http://saferlivingfoundation.org)
If the presenting symptom is genital soreness, for example, GPs may feel confident and competent to prescribe medication to manage sexual arousal. For mental health issues, such as obsessive–compulsive thinking about sex, GPs may prefer to refer the patient to a psychiatrist or mental health service. However, there is still likely to be great variation, even between mental health clinics, as to their confidence and readiness to prescribe medication to manage sexual arousal, especially it seems where there is the possibility of sexual offending.

While the National Offender Management Service facilitates this provision for prisoners in the system, it is down to community healthcare professionals to manage individuals presenting with hypersexuality in the community. It is not clear how well those working in the community are able to deal with hypersexuality and the issues it raises. Where effective management is lacking we are leaving both the patient and the rest of the community open to risk.

Declaration of interests
Belinda Winder is leading the national evaluation of medication to manage sexual arousal in individuals convicted of a sexual offence. This evaluation is funded by the National Offender Management Service, HM Prison Service, NHS England and Nottingham Trent University.

REFERENCES

About the author
Belinda Winder is a professor of forensic psychology and heads up the Sexual Offences, Crime and Misconduct Research Unit (SOCAMRU) at the School of Social Sciences, Nottingham Trent University. She is also co-founder and trustee of the Safer Living Foundation charity, set up to prevent further victims of sexual crime. Professor Winder has been responsible for leading the mixed method evaluation programme of medication to manage sexual arousal at Whatton, a category C prison for adult male sex offenders, near Bingham, Nottinghamshire. She also initiated the first prison-based service user research and evaluation group for individuals who have committed sexual offences. Current projects include research about dementia, autism, internet sexual offending, prevention, the role of religion and spirituality in desistance, and research with transgender prisoners who have committed sexual offences.