

# Sexual Addiction in Association with Obsessive–Compulsive Disorder

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## Abstract

*A case of hypersexual behavior occurring in association with obsessive-compulsive disorder (OCD) is described. This patient had non-paraphilic heterosexual multiple partner behavior or sexual addiction. The patient also exhibited nonsexual obsessions and compulsions diagnostic of obsessive-compulsive disorder. The case is presented for its clinical interest, because sexual addiction is rare especially in association with OCD. Another interesting observation from this case was that the symptom of increased sexual behavior in our patient was found to distinctly different from the OC symptoms from psychopathological perspective. We intend to highlight the fact that hypersexual behavior in OCD patients need not necessarily be obsessive-compulsive in nature and as such there is a strong case for considering hypersexual behavior as a separate diagnostic entity in future classificatory systems (German J Psychiatry 2010; 13(4): 171-174).*

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## Introduction

Hypersexual Disorder or sexual addiction has been primarily characterized as compulsive, impulsive, a behavioral addiction or a sexual desire disorder. Over the years, a range of different terms have been used to refer to such patients, including “Don Juanism” and “nymphomania” (Fenichel et al., 1945). Although the DSM III- R section on sexual disorders not otherwise specified includes the term “non-paraphilic sexual addictions,” this term was dropped from DSM-IV.

Various terms have been used for describing the symptom complex of increased sexual behavior. The concept of “sexual compulsivity” (Coleman et al., 1990) is based on the idea that there is a phenomenological and psychobiological overlap between this entity and OCD. In contrast, others have used the term “sexual impulsivity” and emphasized the overlap with disorders of impulse control (Barth et al., 1987). The notion of sexual addiction has also been proposed, again

based on putative similarities with addictive disorders (Goodman et al., 1998). “Paraphilia-related disorder” has been suggested in view of the high co-morbidity with, and phenomenological similarity to, paraphilias (Kafka et al., 1994).

The lack of an accepted term has arguably contributed to the relative paucity of research in this area. In keeping with DSM’s emphasis on descriptive phenomenology rather than unsupported theory, the term “hypersexual disorder” is perhaps most appropriate.

Hypersexual disorder is usually underreported though it is commonly encountered in clinical practice. Possible reason for this discrepancy could be a tendency to include the symptom complex of excessive sexual behaviors as a part of a patient’s existing psychiatric diagnosis rather than entertaining the possibility of presence of an additional diagnosis of hypersexual disorder/sexual addiction in the patient. We are describing a case of obsessive-compulsive disorder in which careful evaluation revealed the presence of a psychopathologically distinct entity of hypersexual disorder.

## Case Report

A 25 year old married Muslim male, truck driver by occupation with no formal education, was brought to the psychiatry outpatients department of Guru Tegh Bahadur Hospital by his wife with a 5 year history of increased sexual activity. He reported having sexual intercourse up to 20 times daily. He would arrange to meet a female acquaintance almost daily and through her help he would be introduced to 5–10 others. Being a truck driver, he would travel to different places and at every new place, he would arrange willing female partners for satisfying his uncontrollable sexual desires. He reports that by offering money or free trip he would lure the women into having sexual intercourse with him. On most occasions, he would feel so overwhelmed by his compelling sexual needs that he would start sexual act without using condom and on few occasions he did perform sexual intercourse outdoors in broad daylight. Though he was wary of doing sexual acts outdoors, he would not be able to delay his sexual impulses and felt almost driven to commit sexual intercourse instantly. He reported having non-orgasmic sexual intercourse sequentially and recurrently. A preference for middle aged women was initially expressed but the patient would usually accept any willing female partner that he would come across. The patient considered himself to be “addicted to being with different women”. There appeared to be little or no guilt or remorse concerning his behavior. The pattern had continued almost daily despite the patient having contracted gonorrhoea. Even though the patient would be distressed by having acquired this disease he would not be able to stop himself from indulging in indiscriminate sexual intercourses with different women without using condom.

His behavior also interfered with punctuality and the ability to maintain regular employment. Consequently he would work for different employers after losing job with one. On few occasions he would suffer significant fall in his daily earnings due to these job changes and because of this he would have frequent arguments with wife at home. The wife came to know about the patient’s excessive sexual indulgence with different women around six months back only from one of her female acquaintance with whom the patient was reportedly having frequent sexual intercourse. The wife reported that when the patient would be at home he would insist for frequent sexual intercourses with her much against her will and if she would resist he would thrash her and threaten to abandon her. Consequently she would be forced into submitting to his sexual needs. Recurrent daytime thoughts about sexual activity were reported and the patient would indulge in masturbation, sometimes in front of others without feeling any shame about it.

Since last 2 years obsessions such as pathological doubt, of contamination and the need for symmetry were present but were not accompanied by magical thinking. Compulsive rituals were reported including washing rituals, counting compulsions, ritualized eating behavior, and arranging compulsions. A compulsion to drink an odd number of glasses

of water daily was reported. Later a compulsion to carry an odd number of condoms was reported, when he did commence taking sexual precautions. The patient reported a subjective sense of discomfort on attempting to resist these obsessions.

There was no relevant past medical history and the patient was not on medication at the time of presentation. A family history of obsessive compulsive disorder was elicited in patients elder brother (without any evidence of sexual addiction).

Personal history revealed the presence of immature behavior, limited social integration, stammering and poor academic performance in the adolescence period. The first sexual experience was at 20 years of age with a girl from the neighborhood and since then he would have frequent sexual intercourses with different women.

Aged 25, his premorbid personality was described as introverted and anxious. Relative social isolation was reported. There had been no report of drug or alcohol abuse, and, apart from difficulty in sustaining peer relationships and his remarkable sexual behavior, there had been no features to suggest disordered personality. Family conflict over his sexual practices had led to occasional aggressive outbursts and intermittent verbal abuse by the patient.

Mental state examination revealed no evidence of a persistent mood change or psychotic features. Low self esteem was noted and the patient expressed a longing to feel needed, and a feeling of helplessness at his failure to control his sexual behavior. Features of anxiety noted at interview included blushing and recurrent mannerisms. Motor tics were absent. Physical examination and endocrinological assessment were normal. An MRI scan of the brain was also normal.

A diagnosis of obsessive-compulsive disorder with hypersexual behavior was made. A score of 32 of a maximum total of 40 was noted on the Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) (Goodman et al., 1989), with a score of 15 on obsessive symptoms and 17 on compulsive symptoms. The patient was started on fluoxetine 20 mg/day which was gradually titrated up to 60 mg/day along with weekly cognitive behavior therapy sessions. The patient and his family members were psychoeducated about the nature of patient’s illness. The patient was maintained in regular follow up and the patient exhibited significant improvement in the sixth week of treatment with respect to both OCD and hypersexual symptoms. The patient scored a total score of 15 on Y-BOCS with a score of 8 on obsessive symptoms and a score of 7 on compulsive symptoms. Currently, the patient is maintaining well on fluoxetine 60 mg/day and weekly CBT sessions.

## Discussion

In view of non-sexual obsessions, compulsive rituals, and avoidance behavior, the patient in this case was diagnosed having obsessive-compulsive disorder. However, the predo-

minant symptom in this case was recurrent multiple partner sexual behavior. It could be argued that this behavior was symptomatic of OCD as the patient felt it was beyond his control, it interfered with his routine activities and employment, and symptoms had lasted for over five years. The patient reported that he would feel 'compelled' to find another partner quickly. However, that he did not report attempting to resist the behavior. Also he did not experience his repetitive sexual behavior as distressing, repugnant or unreasonable. To the contrary, he valued his behavior, which he believed made him accepted and wanted by the women. There was no subjective feeling that his behavior was foreign to his personality or inappropriate to his situation, although it had clearly occupied a great deal of his time and had resulted in unpleasant complications. In addition, obsessional and compulsive elaboration of aspects of his sexual practices had appeared such as compulsion to drink an odd number of glasses of water daily and a compulsion to carry an odd number of condoms.

In a study from the US of 36 self-reporting adults with 'compulsive sexual behavior' by Black et al. (1997) reported non-paraphilic compulsive heterosexual multiple partner behavior (or nymphomania) to be part of a spectrum of compulsive sexual behavior, including paraphilic and non-paraphilic behavior. The spectrum includes heterosexual and homosexual behavior, masturbation, transvestism, excessive interest in pornography and voyeurism. Almost two-thirds of the subjects met criteria for a current major mental disorder, most commonly a substance use disorder, an anxiety disorder or a mood disorder, 44% met criteria for at least one personality disorder. Compulsive disorders noted were kleptomania, pathological gambling, pyromania and compulsive exercise. Levine et al., 1982 associated compulsive sexual behavior with acting out, atypical psychosis, alcohol and/or drug abuse, temporal lobe disorders and depression.

Kafka et al. (2002), in three outpatient males samples (total n=240) reported a lifetime co morbidity of hypersexual behavior with obsessive-compulsive disorder ranging from 0–11%.

In a recent study, Reid et al. (2009) studied 59 males seeking psychological help for nonparaphilic hypersexual behaviors and compared their clinical sample to a control group of 54 college age men. The hypersexual sample reported more interpersonal sensitivity/depressive (neuroticism) symptoms, obsessive characteristics, social alienation, and preoccupation than the sample norms of the scale.

Previous descriptions of male non-paraphilic heterosexual multiple partner behavior have not been commonly associated with the diagnosis of OCD.

## Conclusion

This case has no close similarity in the literature. Some features observed in our case are similar to the descriptions provided by Levine et al. (1982) and Black et al. (1997). The diagnosis of OCD rests on clear-cut nonsexual obsessions, compulsions and avoidance behavior. In our case, the pa-

tient's compulsive sexual behavior was not recognized by the patient as something alien, unwelcome, or unreasonable to his personality. In addition, the patient does not report any guilt or remorse due to this behavior. To the contrary, the patient in fact welcomes the social contact and approval his behavior brings along with it. The sense of compulsion to seek further partners is mild and is not resisted; it may be more akin to the indulgence of a strong habit than to the suffering involved in OCD. In other words, the hypersexual behavior as observed in our case appears to follow the pattern of substance dependence/addiction and for this reason a nomenclature of 'sexual addiction' appears appropriate for it. Interestingly, our patient exhibited obsessional elaboration of features associated with his sexual practices (always carrying odd number of condoms). We by virtue of this case report intend to highlight that the symptom of increased sexual behavior in OCD patients need not always be obsessive-compulsive in nature as in our case a detailed evaluation unearthed a different psychopathological entity of 'sexual addiction'. There is a need to reclassify hypersexual disorder as a separate diagnostic category in future classificatory systems.

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