Case Report

Hypersexuality – a cause of concern: A case report highlighting the need for psychodermatology liaison

Era Dutta, Nilesh M. Naphade[1]
Department of Mental and Behavioural Sciences, Fortis Group of Hospitals, Mumbai, [1]Department of Psychiatry, Bharati Hospital, Bharati Vidyapeeth Medical College, Deemed University, Pune, Maharashtra, India

Address for correspondence:
Dr. Era Dutta, Consultant at Fortis Group of Hospitals, Flat-16, 3rd Floor, Kamal Darshan, Sion East, Mumbai - 400 022, Maharashtra, India.
E-mail: dreradutta@gmail.com

Abstract

Sexual addictions are behavioral addictions. Hypersexuality is used to describe non-paraphilic "excesses" of sexual behavior. Hypersexual disorder (HSD) can be accompanied by clinically significant social, personal distress, and medical morbidity. Common medical comorbidities seen with HSD are the sexually transmitted diseases (STDs). We present one such case with management. A psychodermatology liaison clinic would be the ideal one-stop for screening patients with STDs for HSD.

Key words: Hypersexual disorder, hypersexuality, psychodermatology liaison

INTRODUCTION

Sex is the basis of humanity and fundamental for the survival of species.[1] Despite the advances in medical sciences, a surge in the rates of sexually transmitted diseases (STDs) like syphilis since the year 2000 has been seen in the US, the UK, Australia, and Europe, especially among men who have sex with men.[2] The need for excessive reckless sexual contact may lead to be a harbinger for STDs.

The dictionary defines hypersexuality or hypersexual disorder (HSD) as "exhibiting unusual or excessive concern with or indulgence in sexual activity." We have known it historically, in the form of Don Juanism and satyriasis among males[3] and nymphomania in females.

The term "Hypersexuality" itself is vague and often misinterpreted by most. It may begin in a benign way, presenting as excessive masturbation while watching porn or just the want of need of sex. It typically develops into a constant need of some or other types of sexual activity, at times even proving to be risky. As these cases often go unreported, it is difficult to estimate the incidence in the general population. We present here a case of HSD, which was referred to us from the Department of Dermatology. The case highlights the need for continued liaison between departments.

CASE REPORT

An 18-year-old young male was referred by the Dermatology Department to the psychiatry outpatient department (OPD) of our tertiary care hospital. Parts of his face and body were visibly covered in lesions. He was undergoing treatment for secondary syphilis for the past 2 months.

Third in sibship of 3, uneducated, hailing from Uttar Pradesh, the patient reported excessive urge to have sex since the past 6–7 years, which was now causing him woes.

Access this article online

Quick Response Code:

Website: www.ijstd.org

DOI: 10.4103/ijstd.IJSTD_27_16

How to cite this article: Dutta E, Naphade NM. Hypersexuality – a cause of concern: A case report highlighting the need for psychodermatology liaison. Indian J Sex Transm Dis 2017;38:180-2.

Sexual history

The young man narrated his first sexual encounter dated back to the age of 13 years, when he had intercourse with a slightly older consenting male. In his own words, he was "addicted" to seeing pornographic content up to 8–9 times a day, mostly only heterosexual content. Initially, the activity did not hinder his daily life and work; however, over the past 3 years, he was unable to think of anything but "sex" and ways to procure it. He began visiting brothels, engaging in unprotected sex. On occasion, he had sex with consenting older males due to ease of availability, or finally resorted to masturbation.

A year ago, he developed a single sore over his penis and gradually lesions over face, trunk, back, abdomen, and all four limbs, despite which he continued his risky behavior. The lesions worsened and inguinal lymph nodes became palpable. The dermatological workup was detailed stating he was on regular treatment.

Laboratory investigations

The diagnosis of syphilis was confirmed as his rapid plasma reagin (RPR) test showed 1:8 titers. ELISA test was negative. Testosterone and thyroid function tests levels were normal.

Management

He was administered 2.4 million units of benzathine penicillin after test dose, which he did not tolerate. Later, he was started on tablet doxycycline 100 mg BD and antihistaminic at night for itching. He was counseled and recommended to abstain from unprotected sex. Failing to do so, the dermatologist recommended a psychiatric consult.

On mental status examination

A young boy, lean frame, dressed in unclean clothes came into our OPD. He was quite guarded initially but soon opened up. The patient reported no affective or psychotic features, substance use.

Obsessive recurrent thoughts about sex (egodystonic) were noted. He wished to decrease the frequency of being able to think of sex. Compulsion presented in the form of masturbation and sex, up to 4–5 times a day. These were pleasurable to him. There were no homosexual impulses, or paraphillic behavior.

Management (psychiatric)

Counseling the patient was a difficult task. Tablet fluoxetine 20 mg was initiated, gradually escalated to 60 mg. After 20 days, he reported slight improvement in his obsessions and compulsion to masturbate. Cognitive behavioral therapy was then started. Over the next few weeks, there was some decrease in his compulsions. In his last follow-up with the dermatologist, he reported a noteworthy improvement. To our dismay, he had to move to another city for work and hence was lost to follow-up.

DISCUSSION

Kafka is a pioneer in the work related to HSD. The proposal for making HSD a valid diagnosis was rejected due to insufficient data.[4] Kafka has given provisional diagnostic guidelines for HSD [Table 1].

One may reasonably argue that the case described above can be diagnosed as obsessive-compulsive disorder (OCD). However, the overlap between OCD and OCD spectrum disorder along with HSD can be tricky. In OCD, the person does not derive pleasure from performing the activity, unlike HSD.

The term "HSD" does not find a place in the Diagnostic and Statistical Manual of Mental Disorders classification. International Statistical Classification of Diseases and Related Health

Table 1: Proposed diagnostic criteria for hypersexual disorder by Kafka

Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors in association with 3 or more of the following 5 criteria
1. Time consumed by sexual fantasies, urges, or behaviors repetitively interferes with other important (nonsexual) goals, activities, and obligations
2. Repetitively engaging in sexual fantasies, urges, or behaviors in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability)
3. Repetitively engaging in sexual fantasies, urges, or behaviors in response to stressful life events
4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, or behaviors
5. Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others
There is clinically significant personal distress or impairment in social, occupational, or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, or behaviors
These sexual fantasies, urges, or behaviors are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication)
Specify if
Masturbation
Pornography
Sexual behavior with consenting adults
Cybersex
Telephone
Sex strip clubs
Others

Problems-ICD-10 of the WHO, however, makes a provision for two relevant disorders-"Excessive Sexual Drive" (F52.7) and "Excessive Masturbation" (F98.8). Management of HSD is as unclear as the diagnosis. There are no Food and Drug Administration-approved medications. Case reports suggest the use of antidepressants, especially serotonin selective repute inhibitors, mood stabilizers, antipsychotics, and anti-androgens.[5,6]

In the West, sexaholic/sex addict anonymous, based on the model of alcohol anonymous, is widely used. A group of men and women, who share their experiences, help each other become sexually sober. In our country, where sex is still considered a taboo subject, the patients rarely use such bodies.[7]

The purpose of discussing this case is to highlight the importance of consultation-liaison. Often, the patients suffering from STDs can be frowned upon and they themselves are ashamed to broach topics related to sexuality. Dermatology-psychiatry liaison clinics are common in Western countries but are still an emerging concept in India.[8] In our country, dermatologists refer cases to psychiatrists, but a dedicated liaison clinic is virtually unknown. Quite often patients express displeasure when a psychiatric referral is made due to the stigma of visiting the psychiatry department. A major advantage of a combined clinic will be the easy availability of help at one stop.

CONCLUSION

A dermatologist should liaise with psychiatrists or clinical psychologists when screening, managing psychosomatic dermatoses, STDs, or other chronic skin conditions.[9] The representation of psychiatry in undergraduate curriculum is scant. We should sensitize other medical fraternities about the significance of psychiatry. The dermatologists should be taught to be psychologically minded and help screen for psychiatric conditions. Dermatology joining forces with psychiatry can help further reduce the burden of STDs.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. Frascella J, Potenza MN, Brown LL, Childress AR. Shared brain vulnerabilities open the way for nonsubstance addictions: Carving addiction at a new joint? Ann N Y Acad Sci 2010;1187:294-315.
2. Stamm LV. Global challenge of antibiotic-resistant *Treponema pallidum*. Antimicrob Agents Chemother 2010;54:583-9.
3. Waxman SM. The Don Juan legend in literature. J Am Folkl 1908;21:184-204.
4. Kafka MP. Hypersexual disorder: A proposed diagnosis for DSM-V. Arch Sex Behav 2010;39:377-400.
5. Bradford JM. The neurobiology, neuropharmacology, and pharmacological treatment of the paraphilias and compulsive sexual behaviour. Can J Psychiatry 2001;46:26-34.
6. Kafka MP. Successful antidepressant treatment of nonparaphilic sexual addictions and paraphilias in men. J Clin Psychiatry 1991;52:60-5.
7. Jayaraman G. Led by Libido: India is Waking Up to the Illness and Finding Ways to Treat It: Chronic Obsession with Sex. India Today; 3 May, 2013.
8. Orion E, Feldman B, Ronni W, Orit BA. A psychodermatology clinic: The concept, the format, and our observations from Israel. Am J Clin Dermatol 2012;13:97-101.
9. Humphreys F, Humphreys MS. Psychiatric morbidity and skin disease: What dermatologists think they see. Br J Dermatol 1998;139:679-81.