

# The management of hypersexuality in men and women

Sexual Offences, Crime and Misconduct Research Unit  
(SOCAMRU),  
Department of Psychology,  
Nottingham Trent University

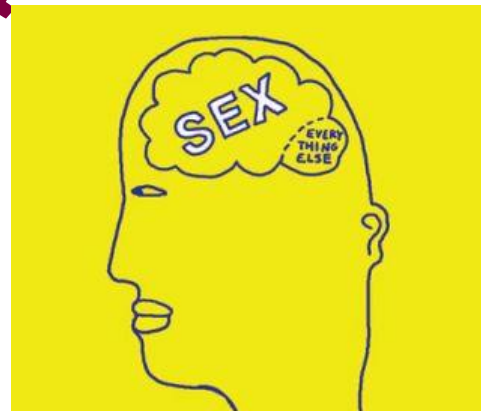
Professor Belinda Winder  
Jessica Faulkner

Acknowledgements: Dr Grubin, Dr Kaul, Dr Hocken, R Lievesley, H  
Elliott, C Norman

# Learning objectives

1. To recognise the impact of hypersexuality on individuals' (male and female) wellbeing
2. To understand the current management of hypersexuality for (i) males and (ii) females
3. To explore whether anti-libidinals (i, Selective Serotonin Reuptake Inhibitors (SSRIs), ii, Anti-androgens and iii, combined) are effective in reducing sexual compulsivity, sexual preoccupation
4. To be aware of any differences between SSRIs and anti-androgens in terms of (i) who they are prescribed for, (ii) effectiveness, (iii) side effects using data from a prison sample of patients
5. To understand the experiences of individuals post-medication for hypersexuality

# Sexual Preoccupation & Hypersexuality



“an abnormally intense interest in sex that dominates psychological functioning” (Mann, Hanson & Thornton, 2010 pg. 198)

Terms used include:

- Sexual addiction (Marshall, Marshall, Moulden & Serran, 2008),
- Hypersexual disorder (Krueger & Kaplan, 2002)
- Hypersexuality (Kaplan & Krueger, 2010).

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# Possible explanations: Sexual Preoccupation & Hypersexuality



**Obsessive Compulsive Disorder (OCD)  
(Garcia & Thibaut, 2010),**

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# Impulsivity and a lack of self-control (Gold & Hefner, 1998)



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- **A poor coping mechanism for depression and anxiety (Bancroft & Vukadinovic, 2004)**



- **Maladaptive personality traits (Hanson & Morton-Bourgon, 2005).**

# Prevalence in the community

- Kinsey et al. (1948) reported that 7.6% of the male sample (n=14,083) had a total sexual outlet (TSO) of 7 or more (this is considered high). This finding contradicts earlier work by Pearl (1925) who claimed high frequencies of TSO are extremely rare.
- Discrepancies in the literature between the terms mean prevalence rates differ; some reasonable estimates are:
  - 3.0% for men and 1.2% for women on scores of compulsive sexual behaviour (used interchangeably with hypersexuality and sexual addiction; Odlaug et al., 2013)
  - 3.1% of women who responded to an online survey were characterised as hypersexual (Klein, Rettenberger & Briken, 2014; Reid, Garos & Carpenter, 2011)

# Prevalence in the community

- More recent research has revealed this figure to be increasing: 12.1% of a community male sample (n=8,718) had a TSO of at least 7 (Klein, Schmidt, Turner & Briken, 2015).
- Kinsey et al. (1953) reported that median TSOs for women (n=5940) were 2.2 per week for ages 16-20, reducing to 1 per week by ages 41-45, and 0.5 by age 60.
- Langstrom and Hanson (2006) reported that 10% of females in their sample (n=1142) displayed behaviours linked to hypersexuality (masturbated 5+ times in the last month).
- Winters, Christoff and Gorzalka (2010)'s online survey reported that 0.95% of women (full sample: n=7,251) had significantly high scores on a sexual compulsivity scale
- Positive correlational links found between pornography consumption and sexual compulsion and hypersexuality in women (Cates, 2015) – and promiscuity and excessive masturbation (impersonal not passive sex)

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# Impact on wellbeing

Detrimental outcomes associated with hypersexuality include:

- Substance abuse (Opitz, Tsytsarev, & Froh, 2009)
- Contraction of sexually transmitted infections (Yoon et al., 2016)
- Unwanted pregnancies (Kafka, 2010)
- Job loss or relationship breakdown (Paunović & Hallberg, 2014)
- Financial losses (Reid et al., 2012)
- Physical injury (Carnes, 1991)
  
- Our research has added to these: interpersonal problems, isolation (social and emotional), depression, anxiety.

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# Current management and treatment of hypersexuality

- Rule out medical causes
- Consider medication to manage sexual arousal – together with therapy / psych treatment

Treated with 2 categories of medication: hormonal and non-hormonal medications

Hormonal drug therapy includes anti-androgens (for example, cyproterone acetate) and gonadotropin-releasing hormone (GnRH) analogues (for example, triptorelin). Cyproterone acetate ([Androcur](#)) is licensed for the control of libido in severe hypersexuality or sexual deviation in adult men. Triptorelin ([Salvacyl](#)) is licensed for the reversible reduction of testosterone to castrate levels in order to decrease sexual drive in adult men with severe sexual deviations.

Non-hormonal drug therapy includes antipsychotics (off-label use) and selective serotonin reuptake inhibitors (off-label use) ([Khan et al. 2015](#)). (From NICE, 2017)

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# Is medication to manage sexual arousal effective?

?

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# Is medication to manage sexual arousal effective?

**YES**

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# Effectiveness assessed in a prison setting

- Hypersexuality/SP is an *enduring psychological risk factor* or long term vulnerability for sexual offending (Thornton & Knight, 2015)
- Sexual preoccupation is a significant predictor for sexual, violent and general recidivism (Hanson & Morton-Bourgon, 2004; Hanson, Harris, Scott & Helmus, 2007)
- Results are typically higher in sexual offender populations, with findings suggesting 44% of incarcerated sexual offenders were considered as hypersexual compared to 18% of a matched community sample (Marshall & Marshall, 2006; Marshall, Marshall, Moulden, & Serran, 2008; Marshall, O'Brien, & Kingston, 2009).

# Research Context

HMP Whatton, a treatment prison in the UK, holds approximately 840 adult males convicted of a sexual offence

42% have a sentence of more than four years

56% are serving an indeterminate sentence including life sentence

## Medication

### Prescription guidelines from Dr Grubin

- Fluoxetine, Paroxetine (SSRIs)
- Cyproterone acetate (CPA, anti androgen)
- Triptorelin (GnRH agonist)
- See Winder et al. (2014; 2017)

for evaluation



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# Evaluation

**136 + adult men referred for medication; initial medication was:**

- 58% SSRIs
- 13% Anti-androgens
- 5% SSRIs & Anti-androgens
- 1% GnRH
- 5% still under assessment
- 18% No medication (declined / not suitable)

## Demographics

- Mean IQ (assessed by WASI or, where available WAIS) = 83.77 (sd = 14.88; 63-114) (*skewed towards lower IQ*)
- Mean age 45.13 (sd = 14.77; 24-81) (*reflecting 'norm' popn*)
- Age at first conviction = 20.33 (sd = 8.08)
- Nationality: Majority British (*reflecting 'norm' popn*)
- History of abuse: Yes, typically - bullying, s/p abuse

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# Evaluation

## Risk

- Static risk (Risk Matrix 2000) scores:
  - Mean score for sexual risk = 3.02 (mode = 4)
    - 34 % high
    - 36% very high
  - Mean score for violence risk = 2.07 (mode = 1)
- Dynamic risk - Structured Assessment of Risk and Need (SARN)
  - Typically scored highly on:
    - Sexual preoccupation
    - Inadequacy
    - Poor problem solving
    - Child abuse supportive beliefs
    - Lack of emotionally intimate relationships



# Measures

## Clinical Measures

- Captured at regular meetings between participants and Dr Kaul (prescribing psychiatrist)
- Data collated during private therapeutic session; used clinically to discuss and tailor medication

## Psychometric measures

Dynamic measures (baseline pre-meds, then approximately every 3 months)

- Sexual Compulsivity Scale (SCS)
  - 10 items; 1-4; used means i.e. between 1-4; 'My desires to have sex have disrupted my daily life'
- Hospital Anxiety and Depression Scale (HADS)
  - Scoring is 0-21 on each sub-scale; caseness 8/21
- Severity Indices of Personality Problems (SIPP 118)

Static measures (conducted once only)

- PAI: Personality Assessment Inventory
  - 22 scales measuring clinical, treatment and interpersonal factors related to personality
- MPI: My Private Interests
  - Short scale measuring offence related sexual interests with 4 subscales 1) an obsession with sex; 2) a sexual interest in children; 3) a sexual interest in violent sex; and 4) multiple paraphilia.

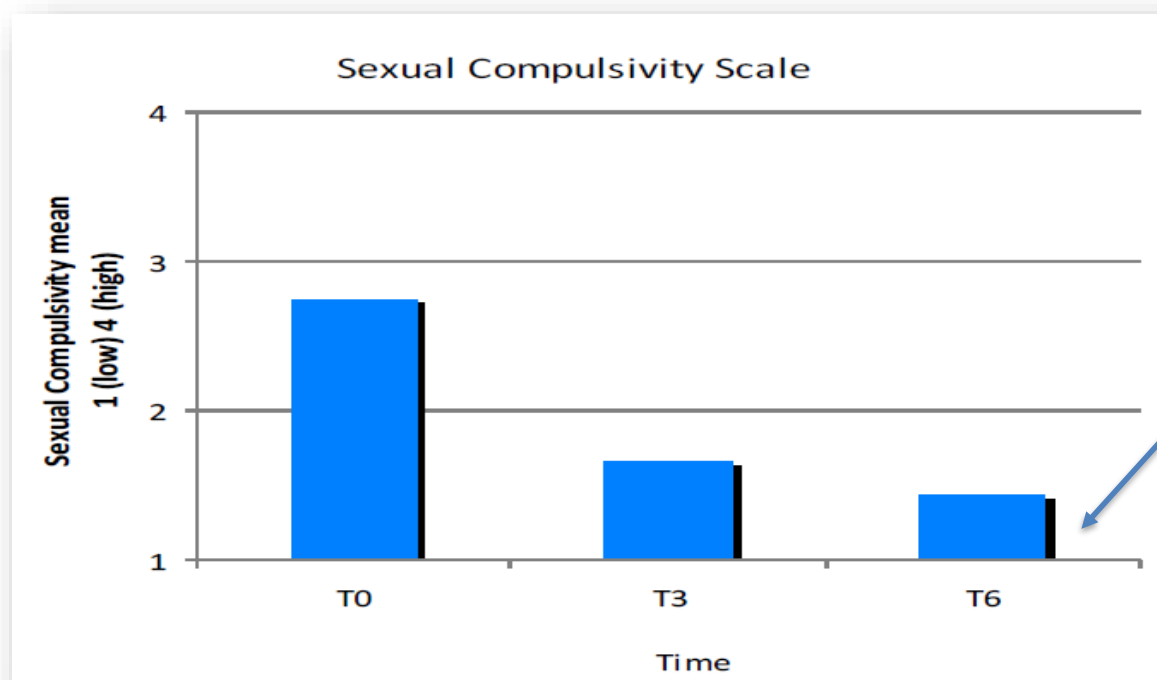
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# Evidence base in prison – HMP

## Whatton

Figure 1: Mean Sexual Compulsivity Scores for participants taking medication to reduce sexual preoccupation: pre-medication (T0), three months post-medication (T3) and six months post-medication (T6).

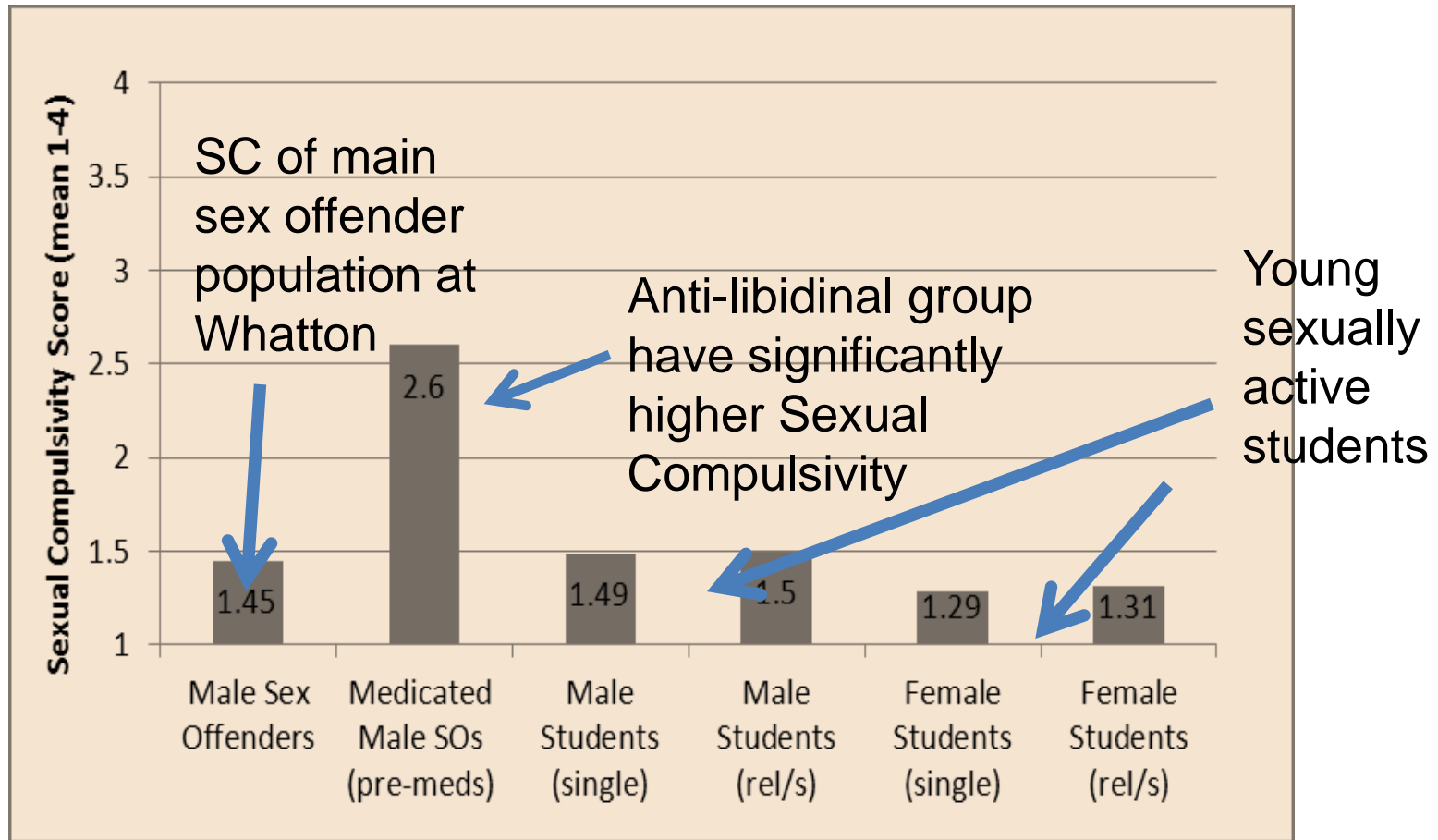


*Below the levels of 'typical' sex offenders*

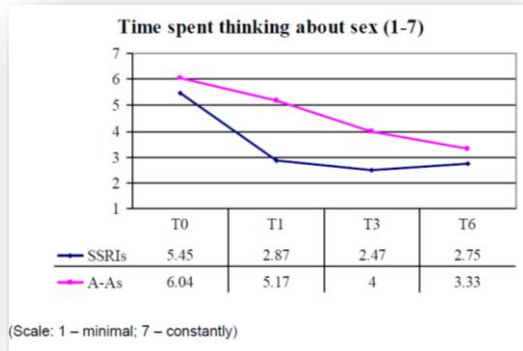
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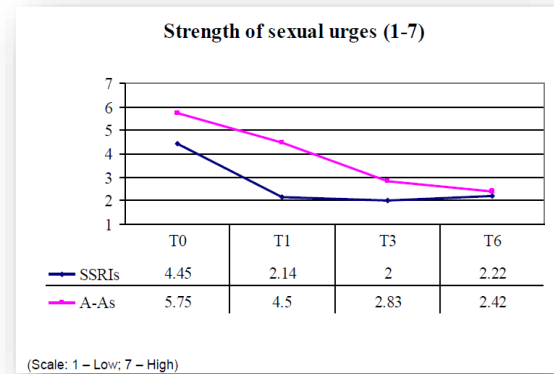
# Sexual Compulsivity



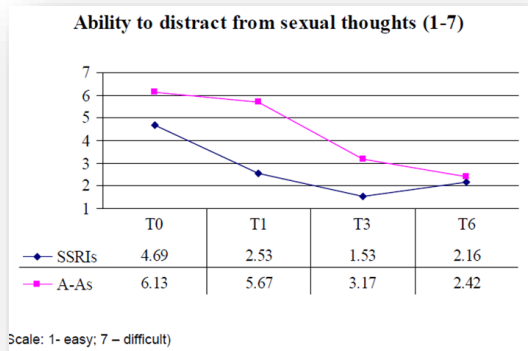
# Evidence base in prison



**Figure 3:**  
Amount of  
time currently  
spent thinking  
about sex for  
participants  
taking (i)  
SSRIs and (ii)  
A-As

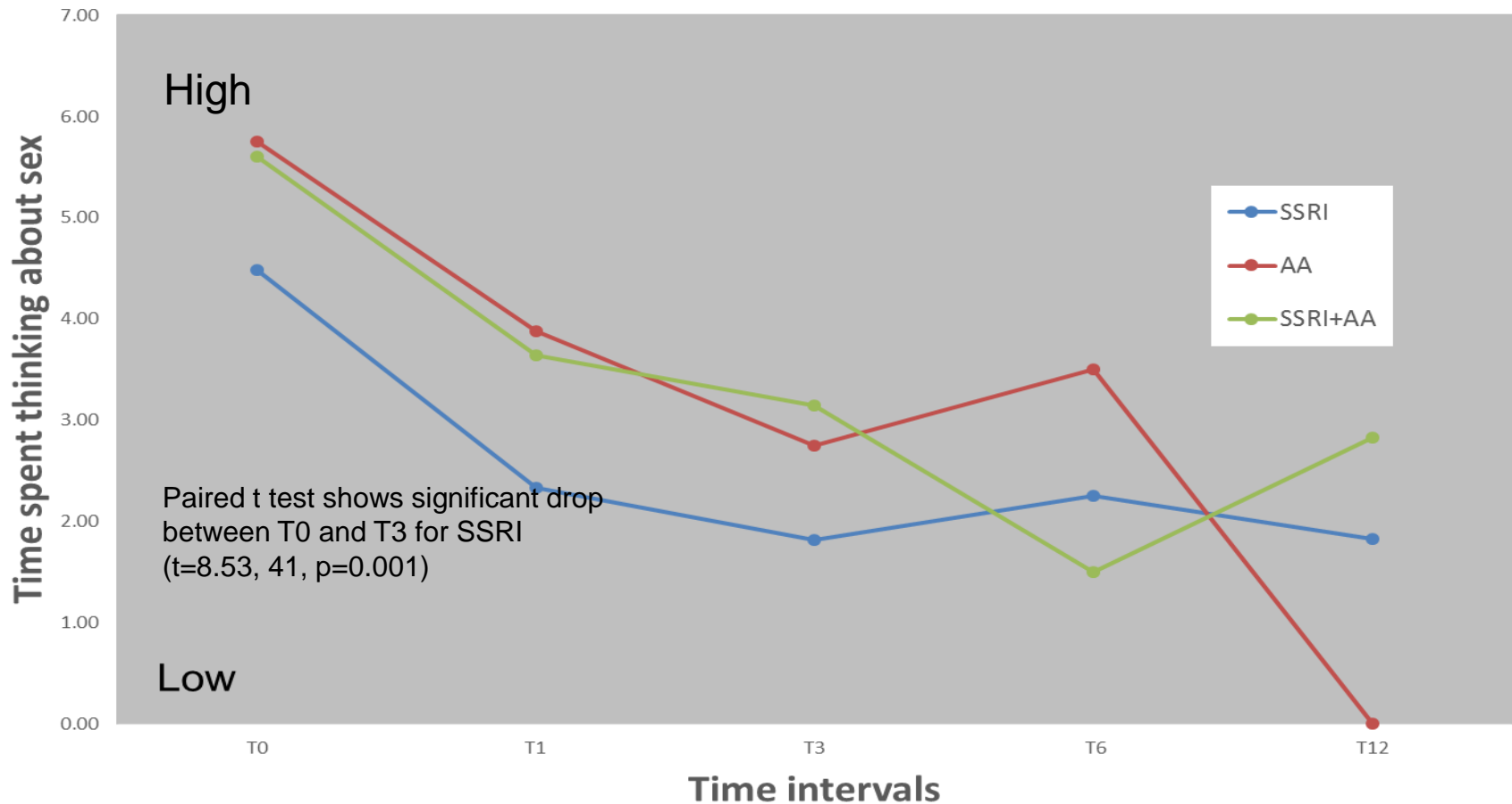


**Figure 5:**  
Strength of  
sexual urges for  
participants  
taking (i) SSRI  
and (ii) A-As



**Figure 4:** Ability  
to distract from  
sexual thoughts  
for participants  
taking (i) SSRI  
and (ii) A-As

# Time spent thinking about sex



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# Psychometric Measures (dynamic)

Table 1: Means (SD) for HADS and sexual compulsivity scale

	Baseline	T3	T6
<b>Depression</b>	<b>6.83 (3.96)*</b>	<b>3.6 (2.87)</b>	<b>4.15 (3.31)</b>
<b>Anxiety</b>	<b>10.56 (4.68)*</b>	<b>6.00 (3.74)</b>	<b>6.63 (3.97)</b>
<b>Sexual compulsivity</b>	<b>2.62 (0.74)*</b>	<b>1.70 (.75)</b>	<b>1.41 (0.44)</b>

\*Significant difference between baseline and 3 months  $p = .001$

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# Psychometric Measures

- Prior to starting medication the research sample more closely resembled the clinical population (admissions to mental health institutes) than the general population on the SIPP-118.
- The facets most problematic were effortful control, self-reflexive functioning, frustration tolerance, emotional regulation and stable self image.
- Both statistical and clinically significant change was observed in adaptive personality functioning on all scales by six months post medication. The percentage of reliable change of adaptive personality functioning was between 13.6% and 38.8%, moving functioning from the maladaptive range to the clinically 'normal' range (general population norms).
- The majority of participants had moved into the healthy range of personality functioning within six months of taking medication.

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# Conclusions

- Promising reductions in measures of clinical measures for individuals taking the medication (both types)
- Complementary to psychological treatment, not a replacement (in prison and?)
- Provides some support for the notion that personality, and in particular, self-control, are key mechanisms underlying hypersexuality and that the improved management of this could result in improved management of sexual thoughts.
- Hypersexuality may be one psychological and behavioural manifestation of maladaptive self-control, presenting as an inability to manage urges, obsessional sexual thoughts, and poor coping (in the form of depression and anxiety).



# Service user reports: effects of medication

- **Sexual preoccupation and associated sexual behaviour**
  - Decreased frequency & intensity of sexual thoughts, fantasies and urges
  - Reduction in masturbatory frequency
  - Increased control of sexual thoughts & ability to distract
  - Physical effects
- **Obsessive compulsive disorder and depressive symptoms**
  - Reduction in symptoms
  - Increased ability to communicate with others and to socialise
- **Impulse and emotional control**
  - Increased ability to recognise inappropriate sexual thoughts
  - Altered nature of fantasies
  - Improved management of emotions.
- **Side effects**
  - Tiredness, drowsiness, nausea, constipation and headaches

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# Final thoughts

- Hypersexuality has implications for physical, emotional and mental health (of self and others)
- Medication has demonstrated significant reductions (both SSRIs and hormonal treatments) pre and post – in samples of adult men
- SSRIs are off-label for hypersexuality currently
- Hormonal treatment (CPA) requires routine monitoring
- For some individuals, it is a precursor to sexual offending – so, if someone is seeking help for this, your next steps are crucial
- For individuals concerned they may offend, there are a few channels of support (see LINKS on next slide) – but this does not mean that they are currently offending.
- There is likely to be an increase in the number of people referring themselves over the next few years....

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# Links

- Safer Living Foundation <http://saferlivingfoundation.org/>
- Lucy Faithfull Foundation <http://www.lucyfaithfull.org.uk/>
- Stop It Now <http://www.stopitnow.org.uk/>
- Online help for people concerned about accessing images <http://get-help.stopitnow.org.uk/>
- Support groups such as Sex Addicts Anonymous <http://saauk.info/en/>
- NICE guidelines :
- <https://www.nice.org.uk/advice/esuom46/chapter/full-evidence-summary#introduction-and-current-guidance-2>

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# Research & Clinical Team

Prof Belinda Winder [belinda.winder@ntu.ac.uk](mailto:belinda.winder@ntu.ac.uk) (contact re evaluation)

Jessica Faulkner

Dr Christine Norman

Helen Elliott

Rebecca Lievesley

Dr Kerensa Hocken

Dr Adarsh Kaul [adarsh.kaul@nottshc.nhs.uk](mailto:adarsh.kaul@nottshc.nhs.uk) (contact re prescribing / medication)

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# Additional slides

From here on – to expand on any points raised and possible qs

# Testosterone levels

- 12 participants on Androcur with pre and post tests
- Serum testosterone levels nmol/L

	Mean (SD) nmol/L	Range nmol/L
<b>Pre treatment</b>	<b>13.47 (6.6)</b>	<b>5.3-23.2</b>
<b>Post treatment</b>	<b>5.10 (2.92)</b>	<b>1.1-11.2</b>

- Androcur significantly reduces Testosterone levels  
 $p=0.0002$
- Pre treatment levels slightly higher than norm

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	<b>Key features</b>	<b>Key findings</b>
<b>Service user studies</b>	<p><b>Aim:</b> To explore the use of anti-libidinals to reduce sexual preoccupation and/or hypersexuality in convicted sexual offenders</p> <p><b>Participants:</b> 19 adult male sex offenders</p> <p><b>Medication:</b> Anti-androgens, SSRIs or combined</p> <p><b>Analysis:</b> Thematic analysis</p>	<ul style="list-style-type: none"> <li>• Reduced sexual preoccupation &amp; arousal</li> <li>• Improved impulse &amp; emotional control</li> <li>• Some noncompliance</li> <li>• No prior knowledge of medication</li> <li>• Concerns about effects &amp; long term use</li> </ul>
<b>Therapist study</b>	<p><b>Aim:</b> To explore the experiences of individuals involved in the referral of pharmacological treatment and those who work with sexual offenders receiving pharmacological treatment</p> <p><b>Participants:</b> 8 intervention staff</p> <p><b>Analysis:</b> Thematic analysis</p>	<ul style="list-style-type: none"> <li>• Offenders' concerns &amp; insight</li> <li>• Lack of feedback</li> <li>• Lack of awareness about treatment &amp; lack of support</li> <li>• Concerns about throughcare</li> </ul>
<b>Offender supervisor study</b>	<p><b>Aim:</b> To explore the perspectives and experiences of offender supervisors in relation to the pharmacological treatment</p> <p><b>Participants:</b> 6 offender supervisors</p> <p><b>Analysis:</b> Thematic analysis</p>	<ul style="list-style-type: none"> <li>• Offenders' reluctance to engage</li> <li>• Lack of feedback</li> <li>• Lack of awareness</li> <li>• Excluded from treatment process</li> <li>• Importance of throughcare</li> </ul>

# Prescribing guidance: Prescribing unlicensed medicines

67. The term 'unlicensed medicine' is used to describe medicines that are used outside the terms of their UK licence or which have no licence for use in the UK.<sup>22</sup> Unlicensed medicines are commonly used in some areas of medicine such as in paediatrics, psychiatry and palliative care. They are also used, less frequently, in other areas of medicine.

68. You should usually prescribe licensed medicines in accordance with the terms of their licence. However, you may prescribe unlicensed medicines where, on the basis of an assessment of the individual patient, you conclude, for medical reasons, that it is necessary to do so to meet the specific needs of the patient.

69. Prescribing unlicensed medicines may be necessary where:

a. There is no suitably licensed medicine that will meet the patient's need. Examples include (but are not limited to), for example, where :<sup>23</sup>

i. there is no licensed medicine applicable to the particular patient. For example, if the patient is a child and a medicine licensed only for adult patients would meet the needs of the child; or

ii. a medicine licensed to treat a condition or symptom in children would nonetheless not meet the specific assessed needs of the particular child patient, but a medicine licensed for the same condition or symptom in adults would do so; or

iii. the dosage specified for a licensed medicine would not meet the patient's need; or

iv. the patient needs a medicine in a formulation that is not specified in an applicable licence.

b. Or where a suitably licensed medicine that would meet the patient's need is not available. This may arise where, for example, there is a temporary shortage in supply; or

c. The prescribing forms part of a properly approved research project.

70. When prescribing an unlicensed medicine you must:

a. be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy

b. take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so

c. make a clear, accurate and legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing an unlicensed medicine.

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# Prescribing guidance: Prescribing unlicensed medicines

Information for patients about the licence for their medicines.

71. You must give patients (or their parents or carers) sufficient information about the medicines you propose to prescribe to allow them to make an informed decision.

72. Some medicines are routinely used outside the terms of their licence, for example in treating children. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population.<sup>24</sup> You must always answer questions from patients (or their parents or carers) about medicines fully and honestly.

73. If you intend to prescribe unlicensed medicines where that is not routine or if there are suitably licensed alternatives available, you should explain this to the patient, and your reasons for doing so.

74. You should be careful about using medical devices for purposes for which they were not intended.

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