



Compulsive Sexual Behaviour Following Childhood Sexual Abuse: A Case Report

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Abstract

Compulsive sexual behaviour (CSB), is characterized by repetitive and intense preoccupations with sexual urges, behaviours, and fantasies. These are distressing to the individual and may result in psychosocial impairment. Even though CSB is not infrequent, not much attention has been given to it in the professional literature. A case of female CSB is reported because of its rarity. A 42 years old female from middle SES a teacher and congregation in charge presented with the complaints of frequent absenteeism from work, not following the daily routine, talking less than before, spending more time in praying than before and decreased appetite of 7 months duration. Detailed history revealed childhood sexual abuse at 12 -14 years of age and compulsive sexual behaviour from the age of 35 years. Clinically she showed features of depression. Further work is required to ascertain the frequency of this disorder in the general population and to establish its natural history, risk factors, psychiatric comorbidity, and medical consequences so that, eventually, treatments may be developed and offered to those in need.

Keywords: *Compulsive sexual behaviour; Sex addiction; Hyper-sexuality; Problematic sexual behaviour; Childhood sexual abuse*

Introduction

Compulsive sexual behaviour (CSB), (sex addiction, hyper-sexuality) presents as preoccupation with recurring sexual fantasies, urges, and behaviours. These cause distress to the individual and/or result in psychosocial impairment [1]. Debate exists about its classification as an impulsive-compulsive disorder, a feature of hypersexual disorder, an addiction, or along a continuum of normative sexual behaviour [2]. Despite the recommendations of the Sexual and Gender Identity Disorders Work Group for inclusion of the disorder, DSM-5 concluded that CSB had insufficient evidence for their inclusion as a disorder regardless of category [3]. The World Health Organization's ICD-11 Working Group on Obsessive-Compulsive and Related Disorders, proposed a different categorization of these behavioural addictions and concluded that conceptualizing CSB disorder under impulse control disorders would be clinically most useful [4]. Barth and Kinder reasoned that CSB is best considered as an impulse control disorder [5]. Even though CSB is not

infrequent, not much attention has been given to it in the professional literature. The current case report was an attempt to understand compulsive sexual behaviour and to examine it in a systematic way. In this paper we describe the findings of a case report of CSB which started after sexual abuse.

Case Report

A 42 years old female from middle Socio-economic background, a teacher and congregation in charge, was brought by her superior coordinator with the chief complaints of frequent absenteeism from work, not following the daily routine, talking less than before, spending more time in praying than before and decreased appetite of seven months duration. Symptoms began insidiously and have been present continuously. History given by informant revealed that patient was apparently all right seven months back. Changes in her behaviour was noticed when she was not following the daily routine. She was not interested in talking to others. She would sit aside always and stare with teary eyes. The

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authorities sent her to a retreat centre where she was given counselling and meditation for 15 days. After coming back, she spent most of her time in praying. She frequently took leave from school and at times failed to inform that she will be on leave. Her appetite was poor. When forced she would eat 2-3 spoons of food. Her weight reduced by 15 Kg within a period of 3 months. She was then referred to a psychiatrist but she never took the medicines. Predominantly her mood was depressed. There was no history suggestive of MR, epilepsy, head injury, neuro-infectious disease or substance abuse. There was no past history of any mental or physical disorder. History as obtained from the patient revealed that she was sexually abused by her uncle when she was 12 years old. She could not open up and tell this to anyone in her family. Her uncle continued to abuse her physically and sexually for two years. After this she decided that she will not marry anybody because she has a spoiled body. (Episode suggestive of depression). Subsequently she joined the training program for religion. She immersed herself in prayers from which she got the strength to overcome her problems. She was maintaining well till the age of 35 years. From that period onwards she had pain in the abdomen for which she was referred to a diagnostic centre. There she was sexually abused by the technician. Since then her sexual drive increased. At night she would read books that has sexual content and would masturbate. As she was the in-charge of the house, all financial dealings are signed by her. She called for tender for the purpose of making furniture for a school. The carpenters who came used to work on the open terrace of the house. She would leave for work in the morning and reach back by 2.30 pm so that nobody is there at her place. She would call one of the helper boys and tell them to massage her back and subsequently have intercourse. In return she would pay them more than their daily wages. This became a routine process. She became more irresponsible at work and would return back home, without informing the school authorities. One day she was found doing such activities by the head carpenter, who began blackmailing her for the sake of money. On mental status examination she was kempt, cooperative, in touch with reality. She regretted her behaviour but was unable to control her urges. Talk was relevant and coherent. She was anxious and depressed with crying spells and fleeting suicidal ideation. There were no features of psychosis. She was advised cognitive behaviour therapy and Fluoxetine 20 mg. daily but was lost to follow up.

Discussion

The definition of “sexual addiction”, given by Goodman, describes it as a form of behaviour that can function both to produce pleasure and to provide escape from internal discomfort [6]. He characterized it as a failure to control one’s sexual behaviour and the continuation of sexual behaviour despite significant harmful consequences. The patient met the criteria of

sexual addiction [7]. Though no large epidemiological studies have been done, the prevalence of CSB is approximately 3-6% in older literature, out of whom 20% are women [7-8]. It is reported that 63% of females with CSB have experienced childhood sexual abuse compared to 39% of males with CSB [9]. The reasons for childhood sexual abuse leading to CSB are still under investigation, but one popular explanation is the trauma theory which postulates that “dissociative defences are used to protect an individual from feelings of helplessness, lack of control, and/or the realities of the traumatic events” [10]. The most frequent comorbidities found include alcohol abuse or dependence, phobic disorders, and major depression or dysthymia [11]. It can be seen in a number of neurological disorders like Alzheimer’s disease and Parkinson’s disease [12-13]. In Parkinson’s disease, dopamine replacement therapies (Levodopa, dopamine agonists) have been associated with CSB [14]. A small number of case studies using naltrexone support its effectiveness at reducing urges and behaviours associated with CSB [15]. Citalopram resulted in significant reductions in the desire for sex, frequency of masturbation, and hours of pornography use per week in a sample of 28 gay and bisexual men compared to placebo [16]. Addition of Naltrexone added to SSRI treatment resulted in reduction of CSB related behaviour [17]. Non pharmacological treatments like psychodynamic psychotherapy and cognitive behaviour therapy have been shown to be effective. Support groups like Sex Addicts Anonymous (SAA), Sex and Love Addicts Anonymous (SLAA) and Sexaholics Anonymous are available [18-20]. Sexual compulsivity in women has been understudied. Further work is required to ascertain the frequency of this disorder in the general population and to establish its natural history, risk factors, psychiatric comorbidity, and medical consequences so that, eventually, treatments may be developed and offered to those in need.

References

1. Fong TW, Reid RC, Parhami I. Behavioural addictions: Where to draw the lines?. *Psychiatric Clinics North Am.* 2012; 279-296.
2. Kraus S, Voon V, Potenza M. Neurobiology of compulsive sexual behaviour: emerging science. *Neuro Psycho Pharmacol.* 2016; 385-386.
3. Grant J, Chamberlain S. Expanding the definition of addiction: DSM-5 vs. ICD-11. *CNS Spectrums.* 2016; 21: 300-303.
4. Grant JE, Atmaca M, Fineberg NA, Fontenelle LF, Matsunaga H, Janardhan Reddy YC, et al. Impulse control disorders and behavioural addictions in the ICD-11. *World Psychiatry.* 2014; 125-127.
5. Barth RJ, Kinder BN. The mislabelling of sexual impulsivity. *J Sex Marital.* 1987; 13: 15-22.
6. Goodman A. Sexual addiction: designation and treatment. *J Sex Marital.* 1992; 18: 303-314.



7. Coleman E. Is your patient suffering from compulsive sexual behaviour. *Psychiatry Annals*. 1992; 22: 320-325.
8. Inaba DS, Cohen W. *Uppers, downers, all arounders: Physical and mental effects of psychoactive drugs*. 8thed. Medford: Cns Productions. 2014.
9. Perera B, Reece M, Monahan P, Billingham R, Finn P. Childhood characteristics and personal dispositions to sexually compulsive behaviour among young adults. *Sexual Addiction Compulsivity*. 2009; 16: 131-145.
10. Guigliamo J. Out of control sexual behaviour: A qualitative investigation. *Sexual Addiction Compulsivity*. 2006; 13: 361-375.
11. Black DW, Kehrberg LL, Flumerfelt DL, Schlosser SS. Characteristics of 36 subjects reporting compulsive sexual behaviour. *Am J Psychiatry*. 1997; 243-249.
12. Dhikav V, Anand K, Aggarwal N. Grossly disinhibited sexual behaviour in dementia of Alzheimer's type. *Arch Sex Behav*. 2007; 133-134.
13. Cooper C A, Jadidian A, Paggi M, Romrell J, Okun MS, and Rodriguez R L, et al. Prevalence of hyper sexual behavior in Parkinson's disease patients: Not restricted to males and dopamine agonist use. *Int J General Med*. 2009; 2: 57-61.
14. Weintraub D, Koester J, Potenza MN, Siderowf AD, Stacy M, Voon V, et al. Impulse control disorders in Parkinson disease: a cross-sectional study of 3090 patients. *Arch Neurol*. 2010; 67: 589-595.
15. Raymond NC, Grant JE, Coleman E. Augmentation with naltrexone to treat compulsive sexual behaviour: a case series. *Ann Clin Psychiatry*. 2010; 22: 55-62.
16. Wainberg ML, Muench F, Morgenstern J, Hollander E, Irwin TW, Parsons JT, et al. A double-blind study of citalopram versus placebo in the treatment of compulsive sexual behaviours in gay and bisexual men. *J Clinical Psychiatry*. 2006; 1968-1973.
17. Raymond NC, Grant JE, Coleman E. Augmentation with naltrexone to treat compulsive sexual behaviour: A case series. *Annals Clinical Psychiatry*. 2010; 55-62.
18. Cooper A, Putnam DE, Planchon LA, Boies SC. Online sexual compulsivity: Getting tangled in the net. *Sexual Addiction Compulsivity. J Treatment Prevention*, 1999; 6: 79-104.
19. McConaghy N, Armstrong MS, Blaszczyński A. Expectancy, covert sensitization and imaginal desensitization in compulsive sexuality. *Acta Psy Scand*. 1985; 176-187.
20. Schneider JP, Irons RR. Assessment and treatment of addictive sexual disorders: relevance for chemical dependency relapse. *Subst Use Misuse*. 2001; 36: 1795-820.