Can Too Much Sex be a Bad Thing?

By Dan J. Stein, MB, and Donald W. Black, MD

Psychiatry has a long tradition of believing that too much sex is a bad thing. The classical literature provides detailed accounts of men and women who demonstrated apparently pathological sexual appetites. Since Freud, psychoanalytic authors have held that masturbation is unhealthy, and psychodynamically oriented thinkers have written on Don Juanism and nymphomania.

On the other hand, the cultural climate of the 1960s and the work of sexologists since Kinsey, has helped give sex a much sexier image. Many clinicians continue to spend a great deal of time convincing patients with sexual hypofunction that sex is natural, healthy, and pleasurable. Mastery of masturbation is now seen as an important first lesson for the patient or couple undergoing sex therapy.

Perhaps the pendulum has swung too far. Quite clearly, there is a substantially large group of patients where excessive sexual activity is accompanied by “clinically significant distress or marked impairment in social, occupational, or other important areas of functioning.” Although rigorous epidemiological and pharmacoeconomic data remains to be collected in this area, for the clinician familiar with these unfortunate patients, the high prevalence and morbidity of excessive sexual behavior is inarguable. Nevertheless, in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), this category of patients is not given a specific label.

Indeed, the question of what to call this disorder is one that is fraught with difficulty, and the lack of consensus has perhaps further contributed to its relative neglect. The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) referred to “nonparaphilic sexual addictions,” and others have also supported the use of the term sexual addiction. Many, however, have argued that this term stretches a metaphor too far. Terms such as sexual compulsivity or sexual impulsivity again seem to have both pros and cons.

In this issue, contributors summarize some of the available knowledge on patients with excessive nonparaphilic sexual fantasies, urges, or behavior. Black describes the epidemiology and clinical features; Stein and colleagues review its putative neurobiology; Kafka, a pioneer in the psychopharmacology of these symptoms, reviews various pharmacologic approaches. Finally, Stein and Black suggest the term hypersexual disorder, and put forward relevant diagnostic criteria. We hope that this issue will increase clinicians’ awareness of this entity, and also encourage sorely needed rigorous research.
Published study results (n=29):

- **ADDERALL** produced a statistically significant, dose-related increase in objective measures of behavior (number of age-appropriate math problems attempted and math problems correct) as compared to placebo.

- The duration of action of **ADDERALL** effects on behavior were dose dependent.

- No unusual or serious side effects were noted in this study.

**ADDERALL** usage data (n=61) indicate that OVER 90% of patients can be maintained on a dosage frequency of 1-2 times per day.

**ADDERALL** is generally well-tolerated—adverse reactions have seldom been reported (most frequently reported adverse reactions include anorexia, insomnia, stomach pain, headache, irritability, and weight loss).

As with most psychostimulants indicated for ADHD, the possibility of growth suppression and the potential for precipitating motor tics and Tourette's syndrome exists with **ADDERALL** treatment and, in rare cases, exacerbations of psychosis have been reported. Since amphetamines may have a high potential for abuse, **ADDERALL** should only be prescribed as part of an overall multimodal treatment program for ADHD with close physician supervision.

*Thirty-four patients receiving greater than 40 mg per day were excluded from this analysis.

Please see references and brief summary of prescribing information on adjacent page.

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APPHETAMINES HAVE A HIGH POTENTIAL FOR ABUSE. ADMINISTRATION OF AMPHETAMINES FOR PROLONGED PERIODS OF TIME MAY LEAD TO DEPENDENCE AND MUST BE AVOIDED. PARTICULAR ATTENTION SHOULD BE PAID TO THE POSSIBILTY OF SUBJECTS OBTAINING AMPHETAMINES FOR NON-THERAPEUTIC USE OR DISTRIBUTION TO OTHERS, AND THE DRUGS SHOULD BE PRESCRIBED OR DISPENSED SPARINGLY.

INDICATIONS: Attention Deficit Disorder with Hyperactivity: ADDERAL is indicated as an integral part of a total treatment program which typically includes other remedial measures (psychological, educational, social) for a stabilizing effect in children with behavioral syndrome characterized by the following group of developmentally inappropriate symptoms: diminished attention span, short attention span, hyperactivity, distractibility, impulsivity, and impulsivity. The diagnosis of this syndrome should not be made with finality when these symptoms are only of comparatively recent origin. Nonlocalizing (soft) neurologic signs may be present. The qualitative nature of the symptoms and their sequencing may be such as to operate to highly, hyperactivity, and personality changes. The signs of the complete history and evaluation of the child. The decision to prescribe AMPHETAMINES should depend on the physician's assessment of the chronicity and severity of the child's symptoms and their appropriateness for hyperactivity. Administration of AMPHETAMINES should be noted on the presence of one or more of the behavioral characteristics. When these symptoms are determined to be secondary to the administration of the drug, treatment with AMPHETAMINES should be discontinued. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypotensive crises may result). WARNINGS: Clinical experience suggests that is pancytopenia, hemolytic anemia, and thiamine deficiency may occur. Patients with symptoms of bone marrow depression should be observed closely for potential aplastic anemia. Comparative recent origin. Nonlocalizing (soft) neurologic signs may be present. The qualitative nature of the symptoms and their sequencing may be such as to operate to highly, hyperactivity, and personality changes. The signs of the complete history and evaluation of the child. The decision to prescribe AMPHETAMINES should depend on the physician's assessment of the chronicity and severity of the child's symptoms and their appropriateness for hyperactivity. Administration of AMPHETAMINES should be noted on the presence of one or more of the behavioral characteristics. When these symptoms are determined to be secondary to the administration of the drug, treatment with AMPHETAMINES should be discontinued. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypotensive crises may result). WARNINGS: Clinical experience suggests that is pancytopenia, hemolytic anemia, and thiamine deficiency may occur. Patients with symptoms of bone marrow depression should be observed closely for potential aplastic anemia.
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