CASE REPORT

Intellectual disability complicated by sexual addiction: an uncommon presentation of a common condition

Nicholas Tze Ping Pang,¹ Ruziana Masiran²

¹Department of Psychiatry,
Universiti Malaysia Sabah,
Kota Kinabalu, Sabah,
Malaysia

²Department of Psychiatry,
University Putra Malaysia,
Serdang, Selangor, Malaysia

Correspondence to

Dr Ruziana Masiran,
ruziana78m@yahoo.com

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SUMMARY

A young man presented with high libido for 3 years, associated with preoccupation with sexual thoughts combined with his pursuit of pornographic materials. He had strong psychological cravings for and had spent large amount of money on sex, resulting in a dispute with his family. There were no mood or psychotic symptoms. Medical history revealed recent diagnosis of gonococcal urethritis. Cognitive assessment showed subtle deficiencies in reasoning and executive functions. There was occasional use of alcohol. Sexual addiction with comorbid mild intellectual disability was diagnosed, and pharmacological as well as psychological management were started.

BACKGROUND

There are many cases of intellectual disability with issues related to adaptive and social functioning. However, many of these cases would frequently go undetected until much later as the degree of disability might just be mild. Hence, there is a propensity for them to manifest in an unusual fashion as there has been no attempt in childhood or adolescence for occupational or social skills training.

CASE PRESENTATION

A man aged 22 years of Asian origin has been referred to psychiatry from a genitourinary clinic where he was treated for gonococcal urethritis. He has initially reported of having high libido for the past 3 years, associated with persistent preoccupation with thoughts related to sexual activities throughout the days. He later admitted to having had sexual intercourses with a total of more than a hundred different commercial sex workers since he was 19 years. This has actually increased in frequency over the years as he requires more sexual activities to attain the same degree of sexual gratification. Over a 3-year period, his increased libido has been satiated by having more sexual intercourses per day as well as through widening his search areas for sex workers.

The patient has never experienced his repetitive sexual behaviour as distressing or unreasonable. To the contrary, he has enjoyed his sexual encounters as they made him feel accepted by women. Unfortunately, this pattern of behaviour has resulted in a huge amount of money spent on soliciting sexual services, which he has financed via employment as a shop assistant and occasional loans from family members.

There have been psychological withdrawal symptoms on abstinence from sexual activities. It has also been shown that the sexual activities were carried out to the exclusion of other social and occupational activities, supporting the evidence of their salience in his life. His contact with sex workers has been limited to vaginal intercourses only and he never had problems with any phase of the sexual cycles. There have been no paraphiliac or paedophiliac tendencies and he did not have any criminal or legal involvement. He is heterosexual and does not have gender dysphoria. There were no psychotic or manic symptoms.

Childhood history shows physical abuse by his father and a subsequent poor paternal attachment. Further history demonstrated subtle defects in reasoning and executive functions that were hitherto undetected; he failed all school-based examination and had problems handling money and performing age-appropriate basic calculations in his adulthood. Therefore, he could only perform tasks requiring minimal executive processing and synthesis of information, leading to occupational dysfunction and frequent changing of jobs. There was occasional alcohol consumption, but there have been no alcohol or drug dependence or addiction.

Mental state examination revealed a well-groomed Asian man who spoke coherently and relevantly in a simplistic manner. He was euthymic and there were no perceptual disturbances or delusions. Physical examination was unremarkable.

INVESTIGATIONS

A battery of investigations, including full blood counts, thyroid, liver and renal function tests, were normal. Serum prolactin and testosterone were not raised. He was tested positive for gonorrhoea, but HIV and hepatitis screenings were negative. CT scan of the brain with contrast was normal. Mini-Mental State Examination showed no obvious cognitive deficits.

He has been referred for the Wechsler Adult Intelligence Scale (WAIS) assessment.

DIFFERENTIAL DIAGNOSIS

He was diagnosed with sexual addiction, as per American Society of Addiction Medicine guidelines (2014) which recognised behavioural addictions as of equal standing.¹ At the same time, a strong differential diagnosis was mild intellectual disability with behavioural problems (sexual) as per DSM 5 criteria.² This is based on the identified mild

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deficits in the conceptual (difficulty in academic education), practical (limited understanding of risk in social situation, ie, indiscriminate involvement in high-risk behaviour) and social domains (difficulties in employment). However, further psychological testing with a standardised battery, for example, WAIS, would be helpful in clarifying this.

One differential diagnosis was a bipolar disorder presenting with hypomania, a condition where hypersexual behaviour and sexual indiscretion may represent the 'excessive involvement in pleasurable activities that have a high potential for painful consequences'.² Like this patient, a hypomanic behaviour often generates problems if the afflicted person engages in risky behaviours, which may be attempted regardless of the potential consequences, including sexually transmitted diseases or emotional consequences.

Moreover, most patients with bipolar disorder present within similar age range; between adolescence and early 20s, although some present later in life after having been diagnosed with depression. However, the patient illustrated did not seem to fulfil other criteria to suggest a hypomanic episode.

Another differential diagnosis would be obsessive-compulsive disorder (OCD), where the sexual intercourses could have been carried out to quell uncontrollable feelings of anxiety. However, the thoughts and urges to act out sexually are ego-dystonic in OCD patients, when compared with this patient who has been ego-syntonic in his sexual thoughts and behaviour. Nevertheless, sex itself have been shown to cause an increase in endorphin levels, hence providing a sense of euphoria escape, resulting in sex addiction. Besides, individuals with non-paraphilic sex addiction have been to deliberately act on urges to engage in the sexual activities that they repetitively thought about in order to attain sexual gratification.³

Other than these, the states of hypersexuality could also be induced primarily by drugs or medications or frontal lobe tumours, which have all investigated for and proven to be negative for this patient.

TREATMENT

Motivational interviewing was performed on him and it was found that he was in the action stage with regard to his sexual addiction. Psychological work to develop dissonance and encourage self-efficacy then ensued.

OUTCOME AND FOLLOW-UP

He was followed up under specialised addiction services and the psychological work appeared to have reduced his cravings for sex significantly. However, from an intellectual disability point of view, his age group is long past that suitable for an educational intervention for intellectual disability, for example, referral to special schools or vocational education. Nevertheless, belated recognition of that predisposing factor will facilitate communication and formulation of management plans in the future.

DISCUSSION

Sexual addiction is not recognised in the latest DSM-5.² It was previously documented in the DSM-III R as a descriptor under the general diagnosis of 'Sexual Disorder Not Otherwise Specified'. However, due to insufficient research and lack of expert consensus, it was retracted from DSM-IV and the latest DSM-5 iterations.⁴ This has caused consternation among clinicians treating such patients who now have no diagnostic label to work on. Despite the failure to gain full inclusion status in the latest versions of DSM and ICD classification manuals, sexual

addiction is still a recognised condition according to the American Society of Addiction Medicine.¹ The criteria for this condition share similar features with substance-related addiction.

In lieu of an official position in diagnostic manuals, it is classified by many clinicians as part of an impulsive-compulsive behaviour⁵ that implicates reward systems similar to those of substance addictions, involving dopaminergic and endogenous opiate circuits. This is consistent with present-day thinking on behavioural addictions which proposes shared neurobiological pathways and neuroadaptations with substance addictions, and is corroborated by neuroimaging.⁵ However, a recent review underscores the emphasis of needing to rule out a primary disorder consistent with Axis I on the old DSM-IV.⁵ Its aetiology appears to be multifactorial; there is indeed a need to rule out intellectual disability in addition to other possibilities, for example, frontal lobe tumours and behavioural changes secondary to traumatic brain injury or illicit drug use. Psychologically, there is increasing recognition of the role of childhood abuse and insecure attachment on the development of sexual addiction.⁶ The sexual encounters are theorised to be either 'chemical balms' for long-term hurt or as dissociation to distance oneself from the repressed traumatic memories.⁷ This is perpetuated by cognitive errors, including the belief of the self as damaged and unlovable.⁵

Conventional management of sexual addictions is informed by management of other substance-related addictions, including psychoeducation and insight improvement, motivational interviewing and 12-step programmes tweaked for sexual addiction.⁸ Motivational interviewing has been shown to have effects on neural networks, especially in impulsivity and cognitive control.⁹ Pharmacologically, evidence suggests that in small trials, SSRIs (citalopram) have statistically significant effects on sexual drive and desire.¹⁰

Learning points

- ▶ Intellectual disability can present much later in life with unusual symptoms and should not be overlooked as an aetiology for unusual behaviours.
- ▶ Sexual addiction can mask other underlying psychiatric illnesses.
- ▶ Thorough search for an organic pathology should be performed in the event of unusual or atypical symptomatology.

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