

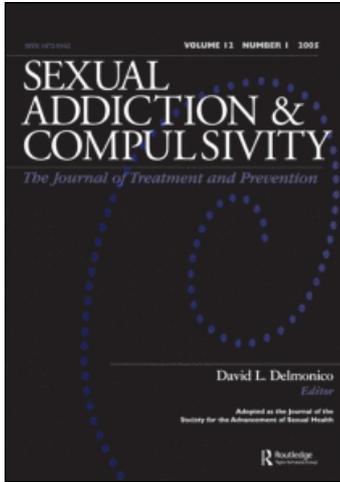
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A Psychiatrist's Approach to a Case of Problematic Sexual Behavior

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EDITORIAL

A Psychiatrist's Approach to a Case of Problematic Sexual Behavior

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INTRODUCTION

In the last edition of the Journal, I highlighted how the biopsychosocial model (Engel, 1977) can be applied to problematic sexual behaviors. My goal was to demonstrate how this model allows us to use empirical research to better understand the etiologies of and treatment options for hypersexual behaviors.

In this editorial, I have asked Dr. Reid Finlayson to join me in discussing a complex case of hypersexual behavior. Our goal is to demonstrate the framework by which psychiatrists conceptualize, diagnose and treat these behaviors. The psychiatric community has often come under scrutiny for “labeling,” “overprescribing,” and failing to approach our patients as “whole.” This article is meant to take readers inside the mind of a psychiatrist as he/she approaches problematic sexual behaviors, and hopefully dispel some of these misperceptions.

In the absence of established “clinical guidelines” or “best practices,” we all must be accountable for the approach we use. Hence, this article is meant to demonstrate the principles of evidence-based psychiatric practice related to hypersexual behaviors and co-morbid psychiatric conditions. At times, this editorial may seem predominantly biological in its approach. This focus is not to devalue psychosocial interventions of other “schools” of thought. Alternatively, our hope is that by demonstrating how psychiatrists apply the research literature to complex clinical problems, we can spark a similar evidence-based approach for the psychosocial interventions we find so important and helpful in treating individuals suffering from this condition. For in the end, the solution to this patient’s problems was a true multidisciplinary team approach.

CASE PRESENTATION: GLENN

Presenting Problem

Glenn is a 50-year-old single male who is a successful business executive. He presented to a specialty outpatient clinic for sexual problems in October of 2006 after being referred from a substance abuse treatment facility. He was referred due to concerns by the treating providers at that facility that he may suffer from sexual addiction.

Psychiatric History

Glenn reported a history of alcohol and drug dependence since his late teens. He had abused a number of other stimulants including ecstasy and crystal methamphetamine in past years and had managed to achieve 5 years of sobriety in the 1980's by attending 12-step meetings. With the exception of individual and group therapy at one treatment center in the past, his sexual behavior had never been a focus of therapy. At the initial assessment, he endorsed drug use with heavy, ongoing daily use of crack cocaine prior to entering an addiction treatment program. He had completed this program, his eighth, 2 months before this assessment. He remained sober in the interim period.

Glenn also had clinical symptoms consistent with a mood disorder including a history of anxiety, depression, appetite loss and weight fluctuation, fatigue, low energy, poor concentration, guilt, and suicidal thoughts, including cutting and several overdose attempts. He also reported having episodes, which would last from 1 to several weeks, in which he required much less sleep, accompanied by expansive, flighty racing thoughts and irritability. He described hypervigilance, both on and off drugs, intrusive memories and vivid nightmares. He had experienced a recurring frightening dream of being buried alive by his father. He had several psychiatric hospitalizations for depression and suicidal behavior.

Glenn had a persistent obsession about compulsively acting out sexually with males. He had never married, never dated and never had intimate involvement with men or women. He began using pornography and masturbation early in his teens. He was first introduced to the gay scene and male prostitution (by his AA sponsor) in his 20's and since then has frequented bars, prostitutes and bathhouses. He estimated having had 7000 partners for sexual interactions, most of which involved prostitution. Glenn both solicited prostitutes and served as an escort. Despite his sexual involvement with males, Glenn did not identify himself as gay. Glenn's sexual behavior occurred both during periods of drug use and sobriety as well as during periods of depression, hypomania and euthymic mood states.

Medical History

Medical history was significant for pneumonia as a newborn and adult onset diabetes managed with Metformin, an oral hypoglycemic agent. At age seven he was hospitalized after diving into an empty swimming pool. He was unconscious for a day or so but suffered no apparent problems. Remarkably, he tested negatively for sexually transmitted illnesses, including HIV and hepatitis B/C.

Family History

Family history included severe alcoholism in both of his parents, sedative-hypnotic dependence, cirrhosis, and an uncle who had suffered “shell shock” in the Korean war.

Social/Developmental History

As a child, between ages 5 and 13, Glenn had been repeatedly sodomized by his father and an uncle. He had been physically beaten by his mother, who still denied that any form of abuse could have had occurred. Neither his sister nor brother suffered abuse in the home. Glenn was bright and made good grades at school. He was also repeatedly sexually abused by a scoutmaster, who gave the boys alcohol, made them dance naked and molested them sexually.

Legal History

His legal history included eight DUIs. He reported having embezzled \$150K impulsively from an employer in the past. He regretted the theft and was never suspected but he managed to repay the funds and escaped detection.

BIOPSYCHOSOCIAL FORMULATION

From the biological perspective, there are several important considerations in Glenn’s case that can help us understand predisposing and perpetuating factors contributing to his hypersexual behavior. Glenn had a long history of alcohol and drug abuse. Stimulants such as crack cocaine and amphetamine are well known to increase dopaminergic tone in the brain, hence contributing to increased sexual arousal and behavior (Berlin, 2008; Kafka, 2010). Glenn’s use of stimulants served to severely escalate his sexual acting out. Glenn also suffered from a co-morbid Axis I mood disorder. Mood disorders

and substance use disorders are often co-morbid in individuals with sexual disorders and there is preliminary evidence for overlap in neuropathological brain circuitry in these conditions (Kafka, 2010). Bipolar disorder carries an additional risk given that manic/hypomanic episodes may be accompanied by hypersexual behavior (Geller & Tillman, 2004). However, given that Glenn's sexual acting out was not limited to manic episodes, bipolar disorder cannot fully account for his behavior. Although uncertain, there may be sexual addiction Glenn's family (father, brother), suggesting a genetic predisposition (Schneider & Schneider, 1996). The family history of alcohol and sedative/hypnotic dependence also may represent a genetic loading (Carnes, 1991). Finally, Glenn's head injury at an early age warrants consideration since it is known that traumatic brain injury can be associated with impaired judgment and impulsivity, which contribute to the development of hypersexual behaviors (Rao, Handal, & Vaishnavi, 2007).

From a psychological perspective, Glenn's psychosexual developmental trajectory was clearly impacted by his extensive trauma history. His repeated emotional, physical, and sexual abuse by individuals whom he trusted (such as immediate family and his scoutmaster) manifested itself in severe impairment in his ability to form secure attachments. Glenn demonstrated elements of avoidant, disorganized, and preoccupied forms of attachment (Ainsworth, Blehar, Eaters, & Wall, 1978). These included inability to bond and establish intimate relationships, multiple sexual partners, participation in sexual acts without affection or emotion, and the desire for closeness to other individuals offset by intense fear of rejection. From a psychodynamic perspective, Glenn demonstrated classic "acting out" behavior as a means for dealing with his emotions. This is seen as a more primitive level of defense against negative affective states (Campbell & Rohrbaugh, 2006). From a cognitive/behavioral perspective, Glenn's self concept was severely impacted at an early age. Being singled out among his siblings as the victim of abuse established a core belief in Glenn as an "outsider" and "defective." He also demonstrated cognitive distortions such as being loved and accepted "only" if he was sexual. Glenn's sexual behaviors were behaviorally reinforced through accepting payment for sexual acts and pairing his drug use with sexual behavior. Drug use served not only to intensify the sexual acts, but to also "numb" away negative feeling states (e.g., depression and anxiety) associated with his sexual behaviors. Finally, there was a compulsive nature to Glenn's behavior that suggested an unconscious drive in Glenn to "master" his early life traumas through re-enactment and trauma bonding.

From a social perspective, Glenn is resilient. He managed to do well in school and hold down executive level employment. He has participated in 12-step programs with success and sobriety in the past. He faces several social challenges including homosexuality, legal charges, financial difficulties, estrangement from family members and isolation. Such social stressors may contribute to feeling of shame, guilt and loneliness that in turn, can fuel sexually compulsive behaviors.

DIFFERENTIAL DIAGNOSIS

DSM-IV-TR (APA, 2000) Multi-axial Diagnosis

Axis I	Sexual Disorder NOS Bipolar Disorder, Type II Post Traumatic Stress Disorder Cocaine Dependence Alcohol Dependence, in full sustained remission
Axis II	r/o Personality Disorder NOS
Axis III	s/p Pneumonia (infancy) s/p Traumatic Brain Injury (age 7) Diabetes Mellitus, Type II
Axis IV:	Legal, Financial, Primary Support, Occupational, Environmental
Axis V:	At initial presentation: 50–55 Highest in past year: 70–75

Discussion

Currently, there is no diagnostic category for sexual addiction. Hence, it is classified within Sexual Disorder, Not Otherwise Specified (NOS)—DSM Code 302.9 (APA, 2000). Glenn clearly meets the criteria for the proposed diagnosis of hypersexual disorder (Kafka, 2010). His behavior is chronic (i.e. greater than 6 months), and is marked by great amounts of time spent planning and engaging in sexual behaviors, engagement in the behaviors as a response to negative affective states and mood as well as stressful life circumstances, inability to cut back on his behaviors, disregard for physical and emotional harm, and personal distress related to the behaviors. While stimulant use and manic episodes may have exacerbated his behavior, they cannot exclusively account for it since his sexual acting out occurred both during periods of intoxication and sobriety as well as during periods of hypomania and euthymic (normal) mood states.

Glenn also meets the criteria for Bipolar Disorder (APA, 2000). Hypomania is best described as periods of elevated mood, flight of ideas, racing thoughts, impulsive behaviors and irritability that are not accompanied by delusions or hallucinations and generally do not cause enough distress or impairment in an individual's life to warrant psychiatric hospitalization. While Glenn was hospitalized many times, his hospitalizations were due to alcohol and drug use and suicidal behavior and never due to mania. Since Glenn also experienced episodes of major depressive episodes, the best diagnosis would be Bipolar Disorder, Type II.

Glenn meets criteria for Post-Traumatic Stress Disorder (APA, 2000) given his history of early, severe, sexual and psychological trauma. He demonstrates re-experiencing (flashbacks, nightmares); avoidance (using drugs, alcohol and sex to avoid negative feeling states) and hyper-vigilance.

Glenn's cocaine, stimulant and alcohol use meet the criteria for chemical dependence (APA, 2000). He demonstrated ineffective efforts to cut back his use, repeated use despite negative consequences, physiologic tolerance to and withdrawal symptoms from the substances, increased time spent engaging in behavior related to his substance use, and failure to meet important life obligations, at times, due to his substance use. His cocaine and stimulant use are active. Since he has not actively used alcohol in the past 12 months, his alcohol dependence is classified as being in remission.

Finally, Axis II pathology, such as antisocial personality disorder, narcissism and borderline personality disorder should be considered in this individual given his history of multiple DUI convictions, embezzlement, and inability to sustain intimate interpersonal relationships.

CLINICAL WORK-UP

The following screening labs were obtained: complete blood count (CBC), basic metabolic panel (bmp), liver function tests, thyroid function tests, Hepatitis screen, HIV screen, syphilis screen, and a urine drug screen. All lab tests were unremarkable with the exception of elevated blood glucose, an elevated hemoglobin A1c (a marker for diabetic control), and cocaine/stimulant positive urine.

Despite the history of head trauma, no neuroimaging or electroencephalogram was obtained. Goodman has proposed the following indication for the use of neuroimaging in patients with problematic sexual behaviors: (a) onset of behaviors in middle age or later, (b) excessive aggression or personality changes, (c) report of auras or seizure-like symptoms prior to or during the sexual behavior, (d) abnormal body habitus, and/or (e) presence of soft neurological signs (Goodman, 1998). Since Glenn did not demonstrate any of the above criteria, it was felt that neuroimaging at this time would be of low clinical value.

BIOLOGIC TREATMENT CONSIDERATIONS

From a psychiatric perspective the goal of somatic treatments was the following: (a) treatment of chemical dependence, (b) mood stabilization, (c) anxiety reduction, and (c) reduction in sexual acting out. The hope was that by improving symptoms in each of these domains, Glenn would be in a more stable and safer place to undergo more in-depth psychotherapy. Table 1

TABLE 1 Biological Work-Up and Treatment Strategies for Hypersexual Behaviors

Chemical Dependence:
Assess need for detoxification (alcohol, benzodiazepines, opiates)
Tailored Pharmacology
Alcohol—Naltrexone, Disulfiram
Opiates—Buprenorphine, Methadone
Traumatic Brain Injury:
Consider neuroimaging (see Goodman's Criteria).
Consider anticonvulsant treatment
Genetic Predisposition:
Discuss with client implications on disease process
Co-Morbid Psychiatric Disorders:
Thyroid Function Studies
Nutritional Assessment: B12, Folate, Albumin
Tailored Psychopharmacology:
Depression—SSRI, SNRI, Bupropion, MAO-I, Tricyclics
Bipolar—Mood Stabilizers, Atypical Antipsychotics, Lithium
PTSD/Anxiety—SSRI/SNRI, Benzodiazepine*, Buspirone
ADHD—Psychostimulants*, Atamoxatine
Psychosis—Typical or Atypical Antipsychotics
Hypersexual Behavior:
HIV/STD testing
Tailored Pharmacology (off label)
Consider SSRI
Consider Naltrexone
Consider Anti-Androgen Treatment for severe cases

*May be contraindicated in patients with chemical dependence.

outlines the approach to the biological work-up and biological treatment plan for an individual with hypersexual behaviors.

Chemical Dependence

Glenn's history of stimulant and cocaine use did not warrant inpatient detoxification. While withdrawal from these substances can be clinically discomforting for patients, it does not pose a life-threatening condition. During withdrawal he was monitored for worsening mood and possible suicidal behavior. He was referred to Narcotics Anonymous for support and recovery. There was no evidence of relapse on alcohol. However, it was decided to assist Glenn's cravings for alcohol and drugs by prescribing naltrexone (Garbutt, 2005). It was also considered possible, based upon a study of juvenile sex offenders (Ryback, 2004) that naltrexone might lower the desire to act out sexually.

Mood Stabilization

The treatment of choice for bipolar disorder is divalproic acid and/or lithium (Crismon, Argo, Bendele, & Suppes, 2007; Saddock & Saddock, 2007). Recently, more psychiatrist are utilizing other anticonvulsants and/or second

generation (e.g. atypical) antipsychotic medications (Crismon et al., 2007). Oxcarbazepine (Trileptal) and quetiapine (Seroquel) are considered adjunctive therapy for bipolar disorders (Dunner, 2005) but were chosen in this case because previous trials of lithium, divalproic acid and lamotrigine had resulted in side effects and/or poor adherence.

Bupropion SR was chosen to assist with residual depressive symptoms. Unlike serotonin reuptake inhibitors, it is less likely that patients with bipolar disorder will have activation in their manic/hypomanic symptoms from this medication (Ghaemi, Hsu, Soldani, & Goodwin, 2003).

Anxiety Reduction

Given Glenn's history of addiction and post-traumatic stress disorder, the use of benzodiazepines to reduce anxiety was contraindicated (Ashton, 2005). Glenn's anxiety and post-traumatic stress was improved through the use of quetiapine and oxcarbamazepine, which have emerging literature to support reduction in anxiety symptoms, although this is an "off label" use of these medications (Malek-Ahmadi, Rowe, 2004).

Sexual Acting Out

Serotonin selective reuptake inhibitors (SSRIs) are generally the treatment of choice for reducing sexual drive (Codispoti, 2008). Due to Glenn's Bipolar disorder, it was decided not to use a SSRI to reduce his sexual drive. The risk of activating a manic/hypomanic phase outweighed the potential benefits of using this class of medication. Glenn was not interested in pursuing any type of anti-androgen treatment. Hence, from a biologic perspective, it was felt that Glenn would be best served with tight mood stabilization to reduce anxiety and depressive states that might contribute to sexually acting out. There is some literature to also support the use of naltrexone in reducing cravings for sexual behavior (Codispoti, 2008; Raymond, Grant, & Coleman, 2010).

PSYCHOSOCIAL TREATMENT INTERVENTIONS

Details of Glenn's psychosocial treatment interventions are outside the scope of this paper. His outpatient CBT psychotherapy with a skilled and experienced therapist commenced with several sessions each week and later involved group therapy. Anxiety reduction was a principal focus of Glenn's ongoing psychotherapy, which also utilized trauma-focused cognitive behavioral therapy (CBT) and eye movement desensitization and reprogramming (EMDR) (Ponniah, 2009). His therapist and psychiatrist often discussed Glenn's treatment process.

Glenn also attended meetings of Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and in addition Sex Addicts Anonymous (SAA). He has been able to celebrate sobriety in each fellowship. He also joined a new 12-Step fellowship, Adult Children of Alcoholic/Dysfunctional Families—Survivors of Incest Anonymous. “An adult child is defined as someone who responds to adult situations with self-doubt, self-blame, or a sense of being wrong or inferior—all learned from stages of childhood. The regression can be subtle, but it is there sabotaging our decisions and relationships.” (ACA, 2006)

PROGRESS

Treatment goals were achieved through a series of outpatient appointments for medication management and one short hospitalization for a recurrence of suicidal thoughts. Glenn had been admitted to hospital depressed, guilty and suicidal in reaction to another episode of stealing money from his boss. He was unhappy with his work and did not find it fulfilling. Glenn did not get caught for the theft, but he was encouraged to return the funds and when he did so he apologized. Although he was allowed to keep his job, he chose to resign. In the process Glenn discovered that his boss resembled one of his childhood perpetrators. The exercise proved to be a useful insight for him, illustrating how he allowed unconscious memories from past events to influence his judgment. In the course of his therapeutic work Glenn became gradually more aware of the childhood antecedents of his sexual acting out. He soon afterwards found employment that he truly enjoys and now reports feeling emotionally stable usually happy. With increasing self worth he has begun to consider that he deserves to have a truly intimate relationship. He has worked on developing his sexual identity. His sexual acting out and alcohol and drug abuse have long ceased and his thoughts and behavior are more focused upon sharing his experiences, strength and hope with other men who are struggling to overcome childhood trauma and associated compulsive sexual behavior.

Maintenance of Glenn’s biopsychosocial treatment plan, including therapy and medication management continues (with much less frequency or acuity), as his success at work and increasing health in relationships grow. It has been possible to gradually reduce the amount of medication required to maintain stability as Glenn demonstrates the effects of his psychological healing in the better life he now enjoys.

FUTURE CONSIDERATIONS

To date, Glenn has not required referral for psychological testing. Such testing may help delineate severe issues of character or psychopathology

that contribute to his compulsive sexual behaviors. If present, these traits can impact treatment decisions and outcome. Since Glenn has responded well to his treatment plan, it has not been felt that psychological testing would be of high clinical yield.

CONCLUSION

The intent of this editorial was to demonstrate how psychiatrists approach individuals presenting with problematic sexual behaviors. The focus was an individual case with compulsive hypersexual behavior in the context of bipolar disorder, alcohol and drug dependence, and complex posttraumatic stress disorder resulting from an extensive trauma history. The first step is gathering a good clinical history and organizing symptoms into criteria-based diagnoses. The next is using this information to create a biopsychosocial formulation that guides treatment. When best possible, the scientific literature is used to guide treatment decisions. Appropriate laboratory tests, neuroimaging studies and psychometric testing may be helpful to rule in or out important somatic contributors both to the sexual behavior and co-morbid psychiatric illness. Finally, close communication with a multidisciplinary team of clinicians ensured proper treatment, adherence, and ultimately remission of symptoms.

The focus of Glenn's treatment from a psychiatric perspective was to identify target symptoms and behaviors to guide a multidisciplinary treatment approach. The focus on diagnostic "labels" was not so much to pigeonhole Glenn into diagnostic categories, but rather to create a broad theoretical infrastructure, which guided evidence-based treatment. Medications were used to help reduce severe mood and anxiety symptoms as well as to curb appetite for alcohol, drugs and sexual behaviors. This paved the way to allowing Glenn to tackle the tough psychosocial issues that contributed to his behaviors. Glenn did well because he had a multidisciplinary team of individuals in communication with one another who utilized evidence-based practice, when available, to guide the recovery process.

AFTERMATH: GLENN'S PERSPECTIVE

As part of Glenn's treatment, we decided to allow Glenn to read this editorial to correct any factual inaccuracies and to solicit his comments on his care. Here is what he wrote us:

"I honor the authors for the care taken to keep my identity protected and safe. It's overwhelming to read my full story after so many years of living in shame and secrecy. I've seen multitudes of help professionals who never really got under the surface to reach me. The editorial misses one key

ingredient and that is the humanity of my psychiatrist. The first appointment with Dr. Finlayson was the turning point for me as he offered his cell phone number to me to use if I felt too overwhelmed between appointments. Never had any help professional gone out on a limb to help keep me safe until that moment. That act of true humanity somehow touched me in a profound way and for the first time I felt loved. Dr. Finlayson went even further in guiding me to a therapist who instantly knew my story and offered the same humanity. I felt loved again. I don't think any help professional in my background ever understood the power of caring versus simply writing prescriptions or offering suggestions. We who have been significantly sexually abused have no voice yet. The crush of the shame and abandonment starting from the first inappropriate touch of a perpetrator is just too great. I offer my story as the beginning of a new day for the treatment of trauma. I hope all who read the editorial will try to bring humanity into the equation at every step of the way as was done by Dr. Finlayson."

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