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Cyber Sexual Addiction: Two Case Reports

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Abstract

Cyber Sexual addiction disorders are becoming quite widespread these days due to the ease of access, low cost and instant gratification. The prevalence rates are quite staggering and involve age groups from 10yrs to 60yrs. These problems also bother the family members especially the spouse or the parents, so systematic and stringent methods should be adopted for the management of these problems. We present two cases of Cyber Sexual addiction and discuss the condition and its treatment.

Keywords: Internet addiction; Cybersex addiction; Cognitive behaviour therapy

Introduction

We are witnessing the growth of a faster paced, technology-based world where there is less need for face-to-face interaction to conduct personal and commercial business. Recognized since the mid-1990s, Internet addiction exhibits signs and symptoms similar to those of other established addictions [1-2]. It is uncontrollable and damaging use of the Internet and is recognized as a compulsive-impulsive Internet usage disorder, one of those in the spectrum of impulse-control disorders discussed in recent psychiatric literature [3-4]. Though the basic epidemiology of the disorder remains unclear, studies in different countries suggest that the population prevalence of Internet addiction ranges from 0.3% in the United States, 0.8% in Italy and 1.0% in Norway to 26.7% in Hong Kong [5-7]. Among adolescents, the prevalence is about 8% in Greece [8]. A growing incidence in adolescence has been reported by researchers in Taiwan and China from about 6% in 2000 to about 11% in 2009 [9-10]. While studies indicate that people suffering from Internet addiction are mostly young males with introverted personality, it has also been shown that the prevalence of the disorder among females is increasing [11]. An association between internet addiction, psychiatric symptoms, and depression among adolescents has been reported [12-14]. Internet addiction is also detrimental to physical health research on patients who were addicted to the Internet, particularly to the massively multiplayer online role-playing games, demonstrated that these games induced seizures in 10 patients [15].

A study on sexuality and the Internet showed that approximately 9 million people, or 15% of Internet users, accessed one of the many top adult web sites in a 1-month period [16]. Three primary factors that promote online compulsive sexual behavior, which have been referred to as the triple-A engine, include easy accessibility, affordability, and anonymity [17]. Online sexual behaviors fall in a range, from normal, or even life-enhancing, to pathological. Individuals with empty and unsatisfying lies continue to use internet to act out their issues through pornography, sex with multiple and anonymous partners, phone sex, and paraphilias. These people find the quick boost produced by the mood-altering experience the computer can provide very enjoyable, and thereby repeat the experience time and again [18]. However, viewing pornography on the Internet can lead to psychological problems which is obvious from the fact that 17% met criteria for problematic sexual compulsivity in one study [17].

Sexual behaviors trigger brain dopamine secretion, which becomes supra-natural at intense levels, such as with frequent use of pornography. In addition endogenous opioid systems is also involved. This mirrors the effects of addictive substances, [19-20] and may explain the addiction potential of sex [21]. A qualitative study of individuals who use the Internet for sexual activity indicated that they experience difficulties with depression, low self-esteem, social isolation, damaged

relationships, career loss or decreased productivity, and financial consequences as a result of their behaviours [22].

The American Center for Online Addiction has identified five types of Internet Addictions including Computer addiction, Information overload addiction, Net gaming addiction, Social network addiction cyber relationship addiction and Cyber sexual addiction [23]. It is also postulated that Cyber sexual addiction is not merely be a sub-type of Internet addiction, but also a subtype of sex addiction [24]. There is no diagnosis of pornography addiction in the current Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) [25], and as with the broader proposed diagnosis of sexual addiction, there is debate as to whether or not the behaviours indicate a behavioural addiction. Two cases of Cybersex addiction with obsessive compulsive disorder and depression are presented and their treatment discussed.

Case Reports

Case 1

A 22 years old unmarried, Hindu, male reported to the outpatients department with the complaints of poor repeated thoughts regarding masturbation, excessive thinking regarding sex desire, and poor concentration of 8 years duration. History revealed that in class 8th when he was about 13 years old he learnt about sex from friends and used to fondle his genitalia while reading books or pictures about sex. This gradually increased and he began watching blue films and surfing internet porn sites. He would spend 6-8 hours in these activities and used to masturbate 6-8 times a day. At the same time he had excessive guilt about his masturbation but could not stop the practice. He started feeling weak, his concentration was affected and his school performance declined and he dropped out from his studies.

There was no history of paraphilia or psychosis. There was history of a solitary seizure about a year back. CT scan of head had revealed a calcified Nodule in right parietal region adjacent to falx. He had been treated by neurologist for the same and there was no recurrence of symptoms. Mental Status Examination showed a kempt and cooperative individual who was in touch with surroundings and maintained eye to eye contact. Rapport was easily established. His voice was audible and clear with coherent, relevant and goal directed speech. Affect was anxious and mildly depressed. There was no perceptual abnormality. Memory, orientation and insight were unimpaired.

On Padua Inventory the score was 101 suggesting obsessive and compulsive symptoms. A high score on factor 1 (impaired control over mental activities) suggest his decreased ability to control undesirable thoughts, difficulties in coping with simple decisions and doubts and uncertainty about ones responsibility in occasional accidents. Whereas high score on factor 3 (checking behaviour) suggests he is having a compulsion to check doors, gas, water, letters, money again and again.

On the BDI a total score of 26 suggests mild level of depressive symptoms in the patient. Features suggest somatic preoccupation, sense of failure, self hate, self accusations, indecisiveness, body image, work inhibition, fatigability and weight loss. YBOCS analysis showed presence of contamination, sexual obsession, and miscellaneous obsession, somatic obsession, cleaning and washing compulsions, checking compulsions. Time occupied by obsessive thoughts is moderate and he feels free from them for nearly 3 to 8 hours a day. He tries to resist these thoughts and on some occasions is able to control them. He spends more time in compulsive behaviour and has extreme distress due to these and thus he tries to resists it. He has insight into his problems but due to his obsessions he avoids doing things, going to places and faces difficulties in making decisions. Overall he is having severe level of obsession and compulsions.

Total number of responses on Rorschach Psycho diagnostics was 31 which suggest that he pays proper attention to the surroundings. Initial reaction time was within average range (24.3 sec) indicating average speed of mental processing. 'Dd' dominated approach suggests a tendency to give overemphasis on minor details. F+% were high (79%) indicating adequate reality contact. High 'M' (8) responses shows impulsivity in the patient, 'Y' responses (2) reveal depressive emotion while 'V' responses indicate inferiority complex in him. High 'Hd' responses (8) indicate fragmented body image. High 'An' responses suggest somatic preoccupation and Afr suggest constricted emotionality. EB ratio indicates intratensive trend of personality. Low 'P' (2) responses reveal poor social conformity.

He was treated with Fluoxetine 60 mg. daily. Motivational interviewing was conducted to assess and help overcome any resistance to treatment. Therapist asked what patient knew about his disorder and its treatment and then suggested that CBT consisting of exposure and response prevention targeting his checking compulsions was recommended and explained what this would involve. Initially the thought of facing his avoidance and distress head on sounded really challenging to the patient. He was informed that his anxiety level may increase initially during exposure sessions and that this anxiety and the time they must expend are the short-term costs of behavioral therapy. Therapist's role would be to guide him to do this in a graded way, at a pace that felt manageable. Therapist explained to the patient how carrying out his compulsive checking and washing activities was reducing his distress in the short term and giving him some initial relief, but in the longer term it was keeping his difficulties going.

Patient was given a description as to how ERP breaks this vicious cycle by gradually exposing him to the things that he is avoiding and that trigger his obsessions, whilst he resists the urge

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to carry out the compulsive activity. Remaining in the exercise without carrying out the compulsion means that his distress/anxiety reduces naturally. As his anxiety or distress naturally reduces, the strength between your obsession and compulsion also reduces. Client felt relieved that there was something that may be able to help him, even if it was a daunting prospect. With the therapist, he then set his goals for moving forwards with the treatment. The patient was given 20 sessions of CBT over a period of 4 months of 45-60 minutes each. The first step was for him to record the details of when he had intrusive thoughts or images and the compulsive activities he carried out and how long he did these for. Therapist explained that doing this would enable them to be clearer about what to put on his hierarchy, how much things were currently affecting him and it would also give them a baseline to measure progress against.

Client met with the therapist again the following week and together they reviewed his list of compulsions also including the websites client feels compelled to surf and the amount of time spent on them. Client was encouraged to talk about things that triggered his compulsions and the things he avoided as a result. From this they moved on to plan his hierarchy of compulsion. With the help of the therapist client listed out his compulsions from the most difficult to the easiest graded on the distress induced by the compulsions and not the time spent on them.

Another Worksheet was prepared to plan to carry out ERP exercises that he would do over the next week. Client was asked to choose to carry out a compulsion that caused moderate distress as starting with the most distressing would discourage the client if the anxiety was too daunting to finish the exercise. Client chose 'Leave for work having only checked the gas stove twice' as it was moderately distressing that is it induced around 60% distress. He went through the conditions of ERP to ensure that the exercises are conducted properly. He would check all the doors, windows and money as usual except the gas stove, which he would only check twice, and then leave. He would remain out of the house long enough for his distress to drop by 50% and then write the duration after this had happened. He rated his distress before exercise level, which was 60%, and then he carried out his compulsions as usual but stopped to check the gas stove only twice. He felt the urge rise to check again when he was about to leave the house and his distress level rose at the start of the exercise to 75%. Initially his level of distress didn't feel like it was coming down, but slowly it did start to reduce. It wasn't easy and he found the urge to go back and check remained strong for quite some time, but then eventually it came down and then he was asked to note the time it took for the distress to decrease by half.

He was really pleased with what had happened and so he repeated it again as planned on his homework sheet. He noticed that although still difficult, he felt more able to manage it as he had managed it once before. He carried on for the week and found that he was able to tolerate the distress that only checking twice gave him more easily as the week went on and towards the end of her week he was ok about doing it and it didn't cause him much anxiety at all. Encouraged by the previous weeks progress client went on to pick another moderately distressing compulsion to carry on in the next week. As the client made progress week after week he felt his anxiety regarding making decisions and communication with others had improved. The most distress inducing compulsion for the client was surfing porn sites when he was at work which led to missing important deadlines at work and he noticed that he tried to resist this the most which led to severe anxious states. After complying with this compulsion he reported feeling guilty and ashamed of his work ethic. He had repetitive thoughts of his colleagues finding out and spent considerable time checking if he had deleted the website history.

A particular pornographic site, a certain time of day or a client's mood just before watching may all serve as triggers that can lead to inappropriate conduct and abuse. Client was encouraged to maintain a daily content log to keep track of when and how they watch.When client tried to resist the compulsion to watch porn at work for the first time, it was really difficult. Client predicted anxiety had been 75%, but when he was preparing for another work he would get more and more anxious.

He recorded his anxiety to be about 90% at the start of the exercise and he found it really difficult to concentrate on other work having not checked the online sites. After about ten minutes he felt he could not tolerate it any longer and went online. He was really disappointed but remembered that if this could happen and he had to try harder next time. Initially he tried not to recheck if he deleted his browsing history or not which was easier than not surfing porn at all. He went for a walk in the office until his anxiety had dropped to 40% and then went back to his cabin. He felt exhausted, but pleased he had carried on. The next day it got a bit easier and so he kept going with it. Once it was easier for him to stop himself from checking his browsing history he went on to cut the amount of time he spent on browsing and later on over a couple of weeks he was able to completely cease his compulsion to watch porn in the office. Though client watches it occasionally at home he now feels that the guilt associated with it previously was no more and he could move on to other activities. As the client's social and family life was suffering because of his addiction and subsequent compulsions he was encouraged to make regular plans with them and client noticed that as his anxiety and compulsions came down he was able to concentrate and build better relations with them.

In the next few sessions focus of the therapeutic session was on the cognitive restructuring of the client. Cognitive restructuring involves systematic identification of the problematic thought patterns which contribute to onset and

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maintenance of the symptoms. Using cognitive restructuring with client will help him reevaluate how rational and valid these interpretations are. Over time, challenging this type of negative cognitions helped the client realize that real life can offer many of the things that the addiction does. Once client became aware of his patterns of faulty thinking, he began to challenge these thoughts more independently of therapy. In this way, he found it more difficult to rationalize or justify his addictive behaviour. On review after six months he was maintaining improvement on medications.

Case 2

A 28 year old male married for 4 years came to the outpatient department along with his parents with the history of preoccupation with internet pornography and disinterest in sex of 2 years duration. His wife had gone to her parental home in the seventh month of pregnancy and now refused to return as she felt neglected due to her husband's habit of watching porn on the net. She was willing to return if he took treatment for the same. History revealed that he first watched pornography at the age of 15 years with his friends. Initially he would watch internet porn infrequently but gradually it became a nightly habit and was followed by masturbation. The time spent watching porn also increased to achieve his desired level of pleasure. Due to his habit he was warned at his place of work after which he stopped carrying his mobile phone to work. However every night he would watch internet porn for 3-4 hours. If he was unable to watch or his time was cut short he developed distress and became irritable.

First few months of marriage he had sex every day and more often on holidays. During this period he had almost stopped watching internet porn. After 8 months of marriage his wife got pregnant and they could not indulge in sex as often as earlier. Gradually he resumed his habit of daily visiting internet porn sites and masturbation which was observed by his wife and the patient had confessed his problem to his wife. Mental Status Examination showed a kempt and cooperative individual who was in touch with surroundings and rapport was easily established. He spoke in low tone with normal speed. Speech was coherent, relevant and goal directed. Affect was anxious and mildly depressed. There was no perceptual abnormality. Memory, orientation and insight were unimpaired. On the BDI total score of 24 suggests mild level of depressive symptoms in the patient. He was treated with Fluoxetine 40 mg daily and given cognitive behaviour therapy and over six months he gradually improved and resumed his marital life.

Discussion

Young [26] proposed a set of criteria for diagnosing Internet addiction based on the DSM-IV [27] criteria for pathological gambling. She selected eight of the 10 gambling criteria she felt applied most readily to Internet use – preoccupation with the Internet, a need for increased time spent online to achieve the same amount of satisfaction, repeated efforts to curtail Internet use, irritability, depression, or mood lability when Internet use is limited, staying online longer than anticipated, putting a job or relationship in jeopardy to use Internet, lying to others about how much time is spent online, and using the Internet as a means of regulating mood – and determined that those patients fulfilling five out of the eight criteria would be considered Internet-dependent. It has been argued that both compulsive and impulsive use of the internet fulfil the criteria as a disorder characterized by: excessive internet use along with loss of sense of time or a neglect of basic drives; tolerance including increasing hours of use or need for better hardware and software; if unable to access computer withdrawal symptoms manifest with tension, anger, and/or depression; and negative consequences including inter-personal issues leading to social isolation, fatigue and poor achievement[28].

Cognitive behavioural therapy is the primary therapy at this time. The goal of this therapy is for clients to disrupt their problematic computer use, to construct their routines with other activities, and to keep more moderate levels of Internet use. Understanding how stress at work or in a marriage can lead person to use the Internet as a "get away" is the focus of therapy Getting rid of the favourites on the computer can make it more difficult to find a favourite Internet site, such as sites that are impulsively accessed when the user is bored. Personal logs of feelings, time of day and Internet activity can be kept over time to determine patterns of Internet use. Clear limits on computer use should be put in place by other family members. Parents might need to limit computer use to school work, to ask the young adult to use the family computer in an open area of the house, or to confiscate the young adult's computer until his or her grades improve. The goal is moderate computer use mixed with age-appropriate social activities, such as involvement in clubs and sports. Taking routine computer breaks, where a person is not on a computer for a certain number of hours, or even days, is a way to disrupt a problematic Internet routine with one that can eventually wean a person from online addictive behaviour.

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