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Friday, May 5, 2017

4:45 P.M.–6:45 P.M. 2 CE Hours

FPL

"Developing Tools and Techniques for Family Members and Spouses to Manage and Deal with Behavioral Addictions, Primarily Gambling Disorders and Hypersexual Disorders"

Presented by Timothy Fong, MD

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Developing Tools and Techniques for Family Members and Spouses to Manage and Deal with Behavioral Addictions, Primarily Gambling Disorders and Hypersexual Disorders

Timothy Fong MD
UCLA Gambling Studies Program
CAMFT 53rd Annual Conference
May 2017

Dr. Timothy Fong

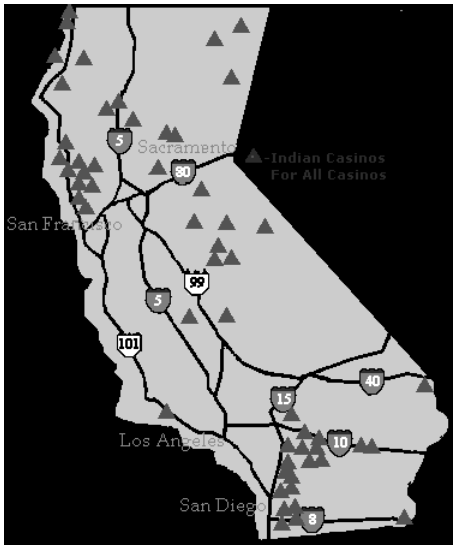
Disclosures:

Speakers bureau :	Indivior
Research Support :	Constellation Health
Consultant:	Onward

Overview

- Gambling Disorders
  - Gambling in California
  - Treatment Options
  - Focus on Affected Individuals
- Hypersexual Behaviors
  - Overview
  - Impact on Families
- Case Studies
- Discussion

Gambling in California



Definition of Gambling

To place something of value on an event of uncertain outcome in the hopes of winning a larger reward

Types of Gambling In California (2017)

State lottery (1985)
Card rooms (73)
~1,500 tables total
Tribal casinos (66)
Total number of slot machines = > 20,000
Horseracing: 5 operating tracks
Total number of lottery vendors = > 20,000
Close proximity to Nevada (Las Vegas and Reno)
No Internet gambling

Gambling in California

- Total Revenue
  - $3 billion (1997)
  - $11 billion (2015)
    - Horse race wagering : $ 37 million
    - Card rooms $ 889 million
    - Lottery: $ 3 billion
    - Tribal casinos $ 7 billion
- 60% Californians gambled last year

Gambling News -- USA 2017

- Urban and Suburban expansion
- Poker “Boom” over but still popular
- Internet Gambling legal in some states
  - Not as successful as once thought
- Movement toward “integrated play” games in casinos and at home
- Destination gambling always popular

Daily Fantasy Sports

- Fantasy Sports
  - Players accumulate points based on the athletic performance of their chosen team
  - Direct competition with peers
  - Tournament or Head to Head
  - Season-long (Traditional)

DSM-5 : Gambling Disorder

- Formerly known as:
  pathological gambling, compulsive gambling, gambling addiction
- Formerly housed in Impulse Control Disorder
- Currently housed in Substance Related and Addictive Disorders

Summary of DSM-5 Criteria for Gambling Disorder

A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:

Preoccupation	Lying
Tolerance	Withdrawal
Chases	Bailed Out
Can't stop	Lost opportunities
Gambles to escape	

Summary of DSM-5 Criteria for Gambling Disorder

B. The gambling behavior is not better accounted for by a Manic Episode

Severity

- **Mild:** Exhibit only 4 or 5 of the criteria, with preoccupation with gambling most frequent criteria
- **Moderate:** Exhibit more of the criteria (6 or 7).
- **Severe:** Individuals with the most severe form will exhibit all or most all of the nine criteria.
  - Jeopardizing relationships or career opportunities due to gambling
  - Relying on others to provide money for gambling losses

DSM-5 Notes

Most Common Symptoms:

Preoccupation and Lying

Most Severe Symptoms

Jeopardizing relationships or career opportunities due to gambling

Relying on others to provide money for gambling losses

DSM-5 Notes

- What should be done about those who meet 1-3 criteria?
- Are we any closer to a biological or objective test?
- How do you categorize stock traders, financial investors?

California Prevalence Study (2005)

n=7,121 respondents, 18 years and older

Problem gambling 2.2%

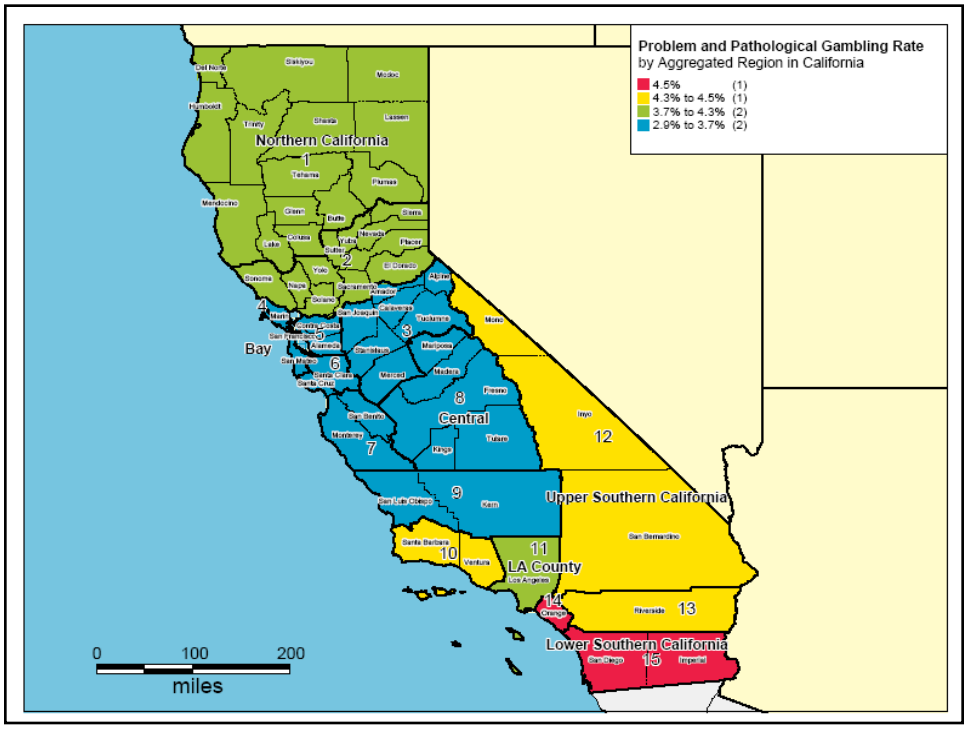
Pathological gambling 1.5%

~1,000,000 problem/pathological cases

Highest Risk: African-Americans, Disabled, Unemployed

According to California Prevalence Data

- Highest risk for gambling disorder:
  - Disabled
  - Unemployed
  - African Americans
  - Adolescents
  - Elderly (over 60)
  - Co-Occurring Substance or Mental Health Disorders



Clinical Characteristics of Pathological Gambling

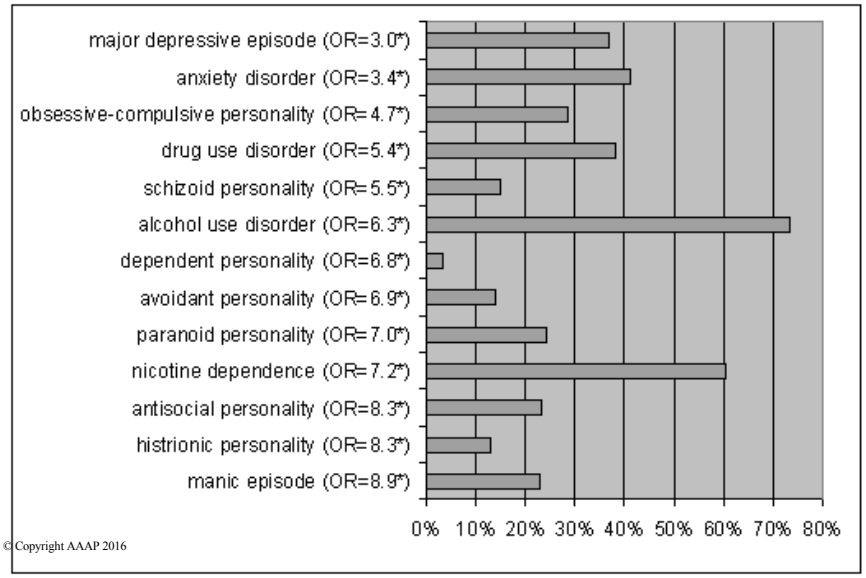
Consequences of GD

- Individuals
  - Mental Health
  - Physical Health
  - Financial Health
- Families
  - Dysfunction, Abuse, Neglect, Drama
- Society
  - Lost time, productivity
  - Economic stagnation
  - Environmental impact

Petry, Stinson, & Grant, 2005

- Nationally representative sample: NESARC
- 43,093 household and group quarters residents aged 18 and older
- Data collected in 2001-2002 survey
- Looked at the prevalence and associations of lifetime pathological gambling and other lifetime psychiatric disorders

Percentage of GDs with Co-Occurring Disorders



Health Impact of Gambling Disorder

- Increased likelihood of stress-related physical problems:
  - migraines, tension headache, IBS, ulcers, insomnia & sexual dysfunction
- GD more likely to have had a physical injury
- GD more likely to have needed ER visit (Grant)
- 36% of GD reported poor/fair physical health (CALGETS database)

GD associated w/ increase in cardiovascular disease

- Review of NESARC Data
  - Focus on older adults (55+)
- GD status was associated with elevated odds for incident arteriosclerosis and heart conditions.
  - Increased risk beyond established risk factors

J Addict Med. 2013 ; 7(6):

UCLA Gambling Sleep Study - Results

- National Epidemiological Survey: (N=3412)
  - GDs were almost 3.5 times more likely to experience a sleep problem compared to individuals who did not have a gambling problem
- Community Survey: (N=120)
  - GDs experience significantly poorer sleep quality and increased daytime sleepiness relative to those that recreationally gamble.

Parhami, Iman, et al. "Pathological gambling, problem gambling and sleep complaints: An analysis of the National Comorbidity Survey: Replication (NCS-R)." *Journal of Gambling Studies* 29.2 (2013): 241-253.

Parhami, Iman, et al. "Sleep and gambling severity in a community sample of gamblers." *Journal of addictive diseases* 31.1 (2012): 67-79.

Screening

Screening

- During the last year, have you become restless, irritable or anxious when trying to stop/cut down on gambling?
- During the last year, have you tried to keep your family and friends from knowing how much you gambled?
- During the last year, did you have such financial trouble as a result of gambling that you had to get help with living expenses?

Screening For Gambling

Brief Biosocial Gambling Screen
(BBGS) *A "yes" answer to any of the questions means the person is at risk for developing a gambling problem.*

1. During the past 12 months, have you become restless, irritable or anxious when trying to stop/cut down on gambling?	YES ☐ NO ☐
2. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?	YES ☐ NO ☐
3. During the past 12 months did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare?	YES ☐ NO ☐

NCRG
NATIONAL CENTER FOR RESPONSIBLE GAMING

www.ncrg.org
www.divisiononaddiction.org

Treatment Planning for Problem Gambling

Similarities to SUD Treatment

- Biopsychosocial Formulation
  - Medications
  - Types of therapies
  - 12-Step Support
- Treatment Delivery Systems
  - Funding aligned with SUD treatment
  - Providers usually from SUD backgrounds

Differences from SUD Tx

- Definitions of successful outcome
  - Does harm reduction apply?
  - Is abstinence enough?
- What are the targets of treatment?
- How do you overcome shame / stigma?
- Cognitive distortions not seen in SUD
- How do you monitor behaviors?

Similarities to SUD Treatment

- Biopsychosocial Formulation
  - Medications
  - Types of therapies
  - 12-Step Support
- Treatment Delivery Systems
  - Funding aligned with SUD treatment
  - Providers usually from SUD backgrounds

Areas of Recovery

- Home
  - Secure, safe base of operations
- Health
  - Physical
  - Emotional
- Purpose
  - Structure and meaning
- Community
  - Social capital and meaningful relationships

California Gambling Education and Treatment Services (CalGETS)
problemgambling.ca.gov

1-800-GAMBLER

1-800-486-8591

Problem Gambling Telephone Interventions (PGTI)

- 1-800-GAMBLER (English, Spanish, AT&T Translation 200+ Languages)
- 1-888-968-7888 (Asian Languages)
  - Weekly sessions over the phone
  - Staffed by licensed therapists
  - **Goal is to engage and transition to outpatient treatment**
- Gamblers and Affected Individuals
  - Motivational Text Messaging

Outpatient Provider Network

- Licensed, OPG-authorized providers
  - MFT, LCSW, PhD, PsyD
- Private offices, clinics
  - Ongoing /support/clinical guidance
  - Therapeutic freedom
  - Group treatment available (2015)
- Access by:
  - Helpline, referrals, online directory
- Gamblers and Affected Individuals

Intensive Outpatient

UPAC (San Diego)

Beit T'Shuvah (LA)

39

Intensive Outpatient Program

- 3 days/week for 4 weeks (12 days)
- Comprehensive, integrated treatment
- Separate gambling-specific treatment
- Utilizes evidenced-based care
  - Beit T'Shuvah Right Action Program (LA)
  - UPAC (San Diego)
- Gamblers Only

Residential

San Francisco

health RIGHT 360
The Best of Walden House and Haight Ashbury Free Clinics

Los Angeles

Beit T'Shuvah
Recover Your Passion - Discover Your Purpose

Residential Treatment

- Provide highest level of care for most severely ill
- 30 days of treatment, >15 hrs./week
- Integrated treatment with SUD
- Los Angeles and San Francisco
  - Beit T'Shuvah: 310-204-5200
  - Health Right 360: 415-762-3705
- Gamblers Only

Clinical Innovations (UGSP)

- Self-Help Workbook
- Client and Therapist Manual
- Drug and Alcohol Counselor
- Partners Manual
- Mindfulness Based Intervention
- Culture and Gambling Projects
- Paraprofessional trainings

CalGETS Providers

CalGETS Providers

	2014-2015	2015-16
Total # Providers	221	219
Age (Mean)	56	57
Gender (Male)	52	57
Gender (Female)	152	155
Number of Years Licensed	12.5	13.6

CalGETS Providers

	2014-2015	2015-2016
Type of License		
MFT	135	151
LCSW	28	29
Phd/PsyD	25	30
# yrs providing treatment to gamblers	4.3	5.4
# of CalGETS clients / month	2.9	2.5

Affected Individuals

Referral Source: AI

	N	%
California Council on Problem Gambling	10	2.4
Casino Signage	1	0.2
Community Presentation	9	2.2
Family/Friends	150	36.5
Former Client	45	10.9
GA or Gam-Anon	18	4.4
Healthcare Professional	56	13.6
Helpline (1-800-GAMBLER)	51	12.4
Media (TV, Radio, Newspaper, Billboard)	8	1.9
Office of Problem Gambling Website	5	1.2
Self-Exclusion Packet	0	0.0
UCLA Gambling Studies Program	2	0.5
Other	56	13.6

Who are the Affected Individuals?

- Significant Others (46%)
- Children of gamblers (27%)
- Parents (18%)

CalGETS Clients – Affected Individuals

	2014-2015	2015-16
PGTI (English/Spanish)	3	14
PGTI (Asian)	8	11
Outpatient	415	411
Group		7
Totals	426	443

CalGETS Clients – Affected Individuals

Age	2014-2015	2015-16
PGTI (English/Spanish)	37.4	50.1
PGTI (Asian)	45.8	45.8
Outpatient	47	46.5
IOP	-	-
RTP	-	-
Group	-	-

CalGETS Clients – Affected Individuals

Gender % (M/F)	2014-2015	2015-16
PGTI (English/Spanish)	33 / 67	14 / 86
PGTI (Asian)	13 / 87	9 / 91
Outpatient	23 / 77	26 / 74
IOP	-	-
RTP	-	-
Group	-	0 / 100

AI: Gam-Anon Attendance at Intake

	N	%
0	351	85.4
1 to 9	45	10.9
10 or more	10	2.4
Mean (SD)	0.87	
Range	0 to 40	

Working With Affected Individuals

Helping Partners in a Relationship with a Problem Gambler

Therapist Manual

Prepared by:
Rory C. Reid, Ph.D., LCSW
Timothy W. Fong, M.D.

UCLA Gambling Studies Program

Funded by:
California Department of Public Health
Office of Problem Gambling

Table of Contents

Disclaimer: This Therapist Manual is designed to assist in the treatment for partners or spouses of problem and pathological gamblers. This manual is currently being evaluated for effectiveness and the results will be made available through the Office of Problem Gambling. These results will help to determine best treatment practices. There is no representation, warranty, or guarantee that this compilation is error free.

Gambling Affects 8-10 Other People

Spouse, parent, child, friend

Some

- also gamble
- Passive, dependent
- Distant, distracted

(Lobsinger & Beckett, 1996)
(Lange, 2010)

Common Questions from AI

- How could this happen to us?
- How could I be so stupid?
- Should I leave?
- How can I ever trust him/ her again?
- Why did this happen?
- How long has this been going on
- Will it happen again?
- What do I tell my family?

Typical Responses From Al

- Anger/ Rage – love/hate relationship – blames addict – decreases as family member accepts disease concept.
- Shame – embarrassed – unable to stop the gambler and impact on others – leads to low self-esteem

Typical Responses from Al

- Hurt – the gambler blames the problems and addiction on the spouse
- Fear and Uncertainty – Not knowing the mood of the gambler or financial uncertainty
- Loneliness – lack of nurturing, rewarding interactions – feels rejected, unloved

What happens to Als over time? (if untreated)

- Declining intimacy
- High suspiciousness –to prevent being taken advantage of
- Emotional detachment –to avoid being vulnerable to inevitable disappointment of gambler
- Defensive anger –to access power to protect self and family
- Intense need for control –to minimize the destruction of gambling

Identifying Enabling Behavior

- Enabling – To intervene in such a way as to prevent the problem gambler from facing the consequences of their actions.
- Protection – To cover up the gambling so that it is not identified as the source. Watch for domestic violence.
- Control – Manipulation, pleading, threatening, yelling, being extra loving – often backfires

Identifying Enabling Behavior

- Assuming Responsibilities – Bail out the gambler by taking over responsibilities – let the natural consequences have their impact
- Rationalization – supports the gambler's denial
- Cooperation – joining the gambler while they gamble
- Rescuing – cheer the gambler up, nurse them back to health

Treatment Principles with Affected Individuals

1. Crisis Intervention

- Assess for Safety
  - Abuse or neglect?
- Assess for disorders in the AI
- Is there need for immediate separation
- What legal issues must be addressed immediately?

2. Educate AIs about the Recovery Process

- Path is seldom smooth, quick or easy
- Both need guidance (nudging)
- They chose their path and speed
- Neurotransmitters
- Monitor enabling
- Lets look ahead, not just back
- Read, study, practice

3. Forgiveness vs. Forgetting

Techniques to use with AIs

- Write a list of things that are difficult to forgive him/her for doing
- Apologize
- Grieve the losses
- Forgiveness doesn't mean it's OK…
- Forgetting

4. Teach Assertiveness

- Tender (Passive)←←← →→→Tough (Bulldozer)
- Dealing with feelings
- Say "Yes" and mean it
- Say "No" and set limits
- Say "No" to demands, violations and thoughtless requests

5. Help to Manage Stress and Making Decisions

- They DESPERATELY need our help
- Decrease stress → Decrease Craving →
- Stop Procrastinating NOW
- What do you have power over?
- Breathe, walk, sit, relax, sleep, eat, play
- e.g." When you gamble/_____, I feel…"
- e.g. "3 things important to me…"

6. Encourage Negotiation

- Small contracts; things in common
- Face problems and changes
- Assess dysfunctional patterns: Who exhibits power over what?
- Which bills to pay first; managing $$$
- How to have fun together again
- The other Vitamin C: "Connection":
  - GA, Gam Anon, friends, family

7. Restore Trust and Hope

- Stop name calling and negative projections
- Reinforce positive behaviors
- Utilize your support system
- Acceptance
- Spiritual release
- Change Today and have Hope in a Better Tomorrow

8. Improving Communication

- Encourage discussion when triggered or gambling urges present
- Set-up system of discussion when relapse occurs
- Identify barriers to communication and solutions to break these down

9. Encourage Gam-Anon

- Support for family members
- Strength through fellowship
- Sharing of ideas on how to reduce enabling and enmeshment
- Not Facilitated

Gam-Anon's Suggestions:

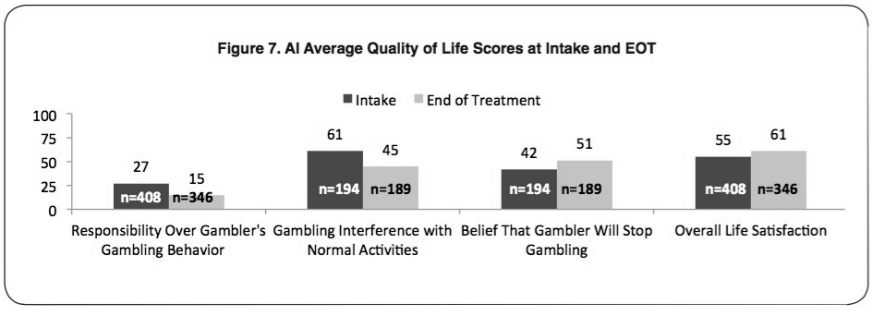
- "admit problem; don't interrogate the gambler; don't work extra just to cover gambling debts; the gambler should call the debtors; money for home and children comes first; find a secure place for valuables; take an honest inventory of YOUR character defects; recovery takes time; forgiveness vs. forgetting"
- Gam-Anon does not suggest bailouts

Gam-Anon Suggestions

- Do not give the gambler money for anything
- Do not cosign loans or other obligations
- Do not sign anything without checking it out with other people
- Do not give the gambler access to your bank accounts

Treatment Outcomes: Affected Individuals

AI : Intake vs. End of Treatment 2014-15



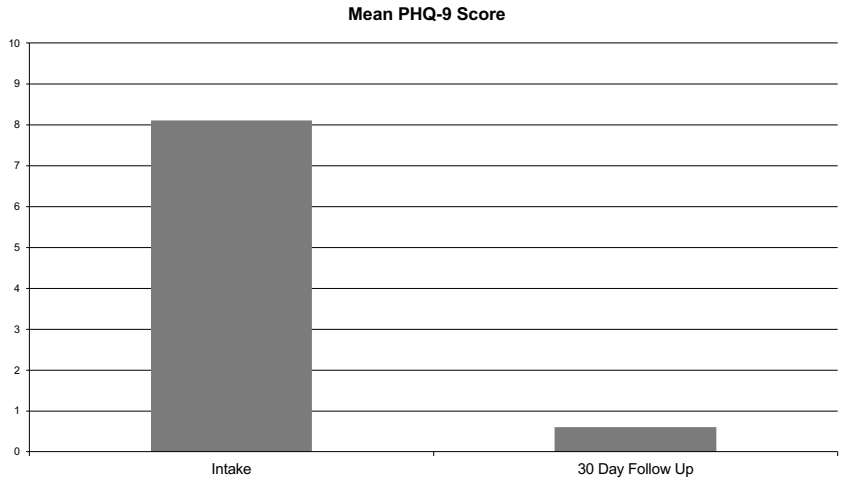
Overall Life Satisfaction (0-100)

	2014-2015		2015-16	
	Intake	End	Intake	End
PGTI (Eng/Span)			46	50
PGTI (Asian)			44	55
Outpatient			56	61

Gambler's Behavior Interfered with Normal Activities (0 – 100)

	2014-2015		2015-16	
	Intake	End	Intake	End
PGTI (Eng/Span)			47	-
PGTI (Asian)			75	53
Outpatient			53	35

AI: PHQ-9 Scores 30 Days Post



Areas for Further Study

- Affected Individuals
  - How many sessions are the most impactful?
  - Gambling patterns of AI
  - Subtyping (spouses vs. children)
  - Deeper follow-up information

Hypersexual Disorder

Recent Email from a Patient

Hello Dr. Fong:

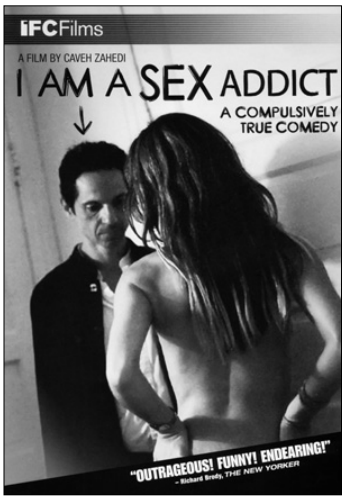
I am a 58-year-old male seeking treatment for sexual addiction. I have excellent insurance with Blue Cross PPO and am hopeful that UCLA has treatment options that might assist me. My addiction is related to Internet porn and cybersex. I do not act out by going to strip clubs, hiring escorts, or having affairs. However, my addiction has affected my otherwise wonderful marriage, and I would like to address it. I have gone to SLAA meetings in the past, and plan to start again.

Recent E-Mail Request

- Dr. Fong,
- Could you assist in this, or do you know anyone- preferably in the Bay Area- you could refer me to?
- Defendant with known foot fetish and erotomania being interrogated by male and female cops. (Defendant kidnapped victim and drove her around for several hours talking and rubbing/sucking her feet.) Female cop keeps taking off her shoe and sock and rubbing her foot, also talking about how she is rubbing her foot. Attorney wants to know if this would affect D's voluntary statement to cops.

Terminology: A Constellation of Adjectives

Hypersexual impulsivity, sexual compulsivity, sexual addiction, sexual dependence, unrestrained sexual desire, sexual disinhibition, hypersexuality, sexual torridity, sexual sensation seeking, sexual desire disorders, excessive sexual desire disorder, hyperlibido, hyperactive sexual behavior, uninhibited sexual desire, paraphilia-related disorders, non-paraphilic sexual disorders, Don Juanism, erotomania, nymphomania, and satyriasis.



Hypersexual Behaviors

- Non-Paraphilic
  - Pursuit of multiple partners
  - Pornography
  - Masturbation
  - Paying for sexual activities
- Paraphilic
  - Non-conventional
    - Objects, situations, individuals

Models of Hypersexuality

- Addiction
- Impulse Control Disorder
- Compulsive Spectrum Disorder
- Extension of Existing Psychiatric Disorder (e.g. Mania)
- Sexual Desire Disorder
- Not a Legitimate Disorder at All

Clinical Characteristics

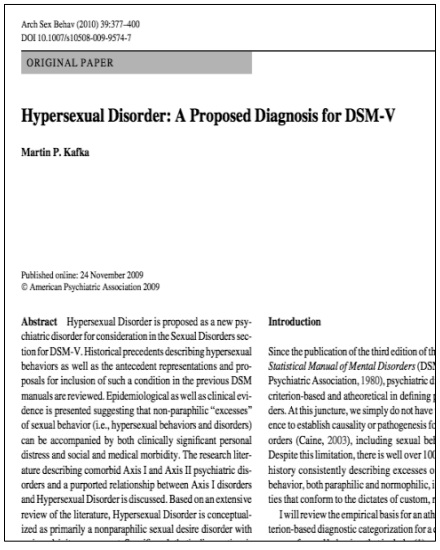
- 5-6% of the population
  - (Coleman, 1992)
- 3:1 ratio male: female
  - (Carnes, 1998)
- Family dysfunction
  - (80% w/ addiction)
    - 40% substance use disorder
    - 36% hypersexual disorder
    - 33% eating disorder

Clinical Characteristics

- 82% sexually abused as children (Carnes, 1991)
- Many raised in heightened sexual atmosphere
- High Prevalence of Co-Occurring Disorders
  - ADHD
  - Major Depressive Disorder
  - PTSD
  - Generalized Anxiety
  - Substance Use Disorder

DSM-5 Proposal for Hypersexual Disorder

- Collaborative effort by Kafka and others on the DSM-5 workgroup for Sexual and Gender Identity Disorders wherein they drafted proposed criteria based on an extensive review of the the empirical literature.
- Kafka published his proposed criteria in the *Archives of Sexual Behavior* in 2010



Arch Sex Behav (2010) 39:377–400
DOI 10.1007/s10508-009-9574-7

ORIGINAL PAPER

Hypersexual Disorder: A Proposed Diagnosis for DSM-V

Martin P. Kafka

Published online: 24 November 2009
© American Psychiatric Association 2009

Abstract Hypersexual Disorder is proposed as a new psychiatric disorder for consideration in the Sexual Disorders section for DSM-V. Historical precedents describing hypersexual behaviors as well as the antecedent representations and proposals for inclusion of such a condition in the previous DSM manuals are reviewed. Epidemiological as well as clinical evidence is presented suggesting that non-paraphilic "excesses" of sexual behavior (i.e., hypersexual behaviors and disorders) can be accompanied by both clinically significant personal distress and social and medical morbidity. The research literature describing comorbid Axis I and Axis II psychiatric disorders and a purported relationship between Axis I disorders and Hypersexual Disorder is discussed. Based on an extensive review of the literature, Hypersexual Disorder is conceptualized as primarily a nonparaphilic sexual desire disorder with

Introduction

Since the publication of the third edition of th
Statistical Manual of Mental Disorders (DS
Psychiatric Association, 1980), psychiatric d
criterion-based and atheoretical in defining
ders. At this juncture, we simply do not have
ence to establish causality or pathogenesis fo
orders (Caine, 2003), including sexual be
Despite this limitation, there is well over 10
history consistently describing excesses o
behavior, both paraphilic and normophilic,
ties that conform to the dictates of custom,
I will review the empirical basis for an ath
terion-based diagnostic categorization for a

DSM-5
Proposed Classification Criteria

A. Over a period of at least **six months**, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:

A1. Excessive **time** is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior.

A2. Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric **mood** states (e.g., anxiety, depression, boredom, irritability).

DSM-5
Proposed Classification Criteria

A3. Repetitively engaging in sexual fantasies, urges, and behavior in response to **stressful** life events

A4. Repetitive but unsuccessful efforts to **control** or significantly reduce these sexual fantasies, urges, and behavior.

A5. Repetitively engaging in sexual behavior while disregarding the **risk** for physical or emotional **harm** to self or others.

DSM-5
Proposed Classification Criteria

B. There is clinically significant personal distress or **impairment** in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.

C. These sexual fantasies, urges, and behavior are **not due** to direct physiological effects of exogenous
substances (e.g., drugs of abuse or medications) or to Manic Episodes.

D. The person is at least **18** years of **age**.

DSM-5
Proposed Classification Criteria

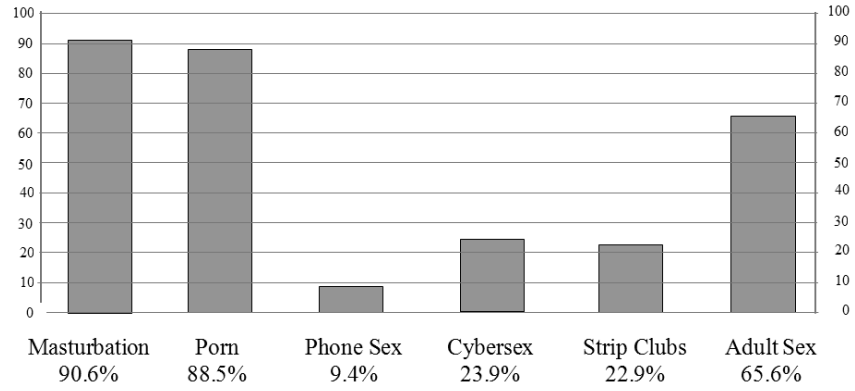
- Specify if:
- In remission (During the past six months, no signs or symptoms of the disorder were present)
- In a controlled environment

DSM-5
Proposed Classification Criteria

- Specify if:
- Masturbation
- Pornography
- Sexual Behavior With Consenting Adults
- Cybersex
- Telephone Sex
- Strip Clubs
- Other:

Manifestations of Hypersexual Behavior

Table 4. Report of Subtypes among Hypersexual Patients (Lifetime & Current)



What Else Was Learned from DSM-5 Field Trial?

Table 6 Onset, course, and escalation trajectories among hypersexual patients (N = 123)*

Trajectories	Hypersexual patients
Onset	
Before age 18†	54.1%
Age 18–25	30.3%
After age 25	15.6%
Rapid/acute ≤ 90 days	17.4%
Gradual, several months, years	82.6%
Course	
Continuous	48.6%
Episodic	51.4%
Escalation	
Amount of time	83.5%
Frequency or intensity	81.7%
Venues/manifestations	62.4%
Associated risk	60.6%

What Else Was Learned from DSM-5 Field Trial?

Table 5 Consequences associated among patients with an HD diagnosis (N = 127)*

Has happened several times	Has happened once or twice	Hypersexual Behavior Consequences Scale (sample items from the HBCS)
1.6%	15.7%	Caused job loss
16.5%	22.8%	Ended a romantic relationship
5.5%	22.0%	Contracted a sexually transmitted infection
0.8%	16.5%	Caused legal problems
29.1%	23.6%	Experienced unwanted financial losses
67.7%	22.0%	Emotionally hurt a loved one
66.9%	11.0%	Interfered with ability to experience healthy sex
73.2%	20.5%	Negatively affected mental health

*Missing data reduced this sample from 138 to 127.
HD = hypersexual disorder

Treatment Options

- Psychopharmacological
- Group Psychotherapy / 12-Step Support
- Cognitive Behavioral Therapy
- Mindfulness Based Stress Reduction
- Cultivating Sexual Health
- Enhancing Cognitive Flexibility / Emotional Regulation
- Stress Management / Coping Skills

Pharmacotherapy

- SSRI – initial therapy
  - Multiple case reports; cohort studies
  - Citalopram 20-60mg vs. placebo in 28 men with Compulsive Sexual Behavior (CSB)
    - Significant decrease ($p<0.05$) in sexual drive, masturbation, pornography use
- Naltrexone – second-line therapy
  - Case reports; case series
  - Dose ranges of 50-150mg daily
- Topiramate
  - Case reports
  - Dosages up to 50mg daily

12-step Groups for Hypersexual Disorders

- Sexual Addicts Anonymous (SAA)
- Sex and Lover Addicts Anonymous (SLAA)
- Sexual Compulsives Anonymous (SCA)
- Sexaholics Anonymous (SA)

Sexaholics Anonymous

- A 12-step fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover

Sex Addicts Anonymous

- A 12-step fellowship of men and women who share their experience, strength and hope with each other so that they may overcome their sexual addiction and help others recover from sexual addiction or dependency

Sexual Compulsives Anonymous

- A 12-step fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from sexual compulsion

Working With Families of Hypersexual Behaviors - Tools and Techniques

Differences From Gambling

- Shame is greater for both parties
- Trust issues are the essential question
  - Personalization much deeper
- Questions about how to restore intimacy (ever again?)
- Resistance to therapy and recovery is more pronounced

Cases

Joe

- 62 year old man referred by primary care physician for “sex addiction”
- No prior psychiatric history or treatment
- In good health, works as a lawyer
- Married 35 years
- 2 adult children

Joe

- Porn was part of his lifestyle through the 70s,80s, 90s,00s
- Hidden away from wife – never discovered
- No sexually acting outside of marriage
- 2015 begins to use Internet to secure escort services
  - Friend showed him how
  - Extended business trip (3 months)

Joe

- From 2015-2016
  - Three times per week $300 / session with escorts
  - Seeks girlfriend experience
- Late 2016, wife discovers accounts online via opened email inbox
  - Triggers intervention with “sex addiction treatment”

Joe

- From January 2017 – March 2017
  - Spend $65,000 on “treatment”
  - Separation and divorce papers filed
  - Behaviors don’t stop
  - Referred by PCP for more specialty care
  - During intake
    - No other psychiatric condition
    - Very little remorse; high compartmentalization
    - Not motivated to stop

Joe’s Wife

- She comes in at 2nd session to review diagnosis / treatment plans / prognosis
- She is angry, bitter, resentful but attends to say “she it doing the right thing”
- Describes marriage of convenience and lack of passion since late 1970s
- More upset at lying / hiding than the actual cheating

Treatment Considerations

- How should treatment look moving forward?
- What should therapist focus on with Joe and Joe's wife?
- What tools should Joe's wife be given?
- What do we make of Joe's behaviors?

Mom

Case Study: Mom

- Son / Daughter contact UGSP concerned about mom's gambling behaviors
- She refuses to come in, so they make an appointment
- 2nd generation, highly educated, MD and JD
- Look like me

Case Study: Mom

- Describe a mother who immigrated at young age
- Stay-at-home
- Tiger mom
- Stoic, never joyous, never passionate
- No grandkids
- Father died 5 years ago

Case Study: Mom

- After husband's death, boredom and loneliness set in
- Starts to go to casinos, via buses to pass time and easy / cheap
- Slot machines only
- Previously, would go every few years with family but doesn't identify as a "gambler"

Case Study: Mom

- Lives alone, manages finances, prior to onset of gambling has over $1.5 million in liquid assets
- Gambling escalates
- After 10 months, children become aware because of financial monitoring (checking statements)
- No behavioral changes

Case Study: Mom

- Children intervene, talk about concern
- Mom refuses to discuss, denies extent of problem
  - Elephant in the room
- As time passes, finances dwindle in front of children's eyes
- More concern and more fighting
- Children threaten to disengage

Case Study: Mom

- By the time children come in:
  - Approximately $400,000 lost
  - They are divided on how to approach situation
    - Daughter – Wants complete cut off
    - Son – wants to move her in with him and his family and take over bank accounts
  - Mom still refuses to come

Case Study: Mom

- 3 sessions with children occur
  - Psychoeducation
  - Gam-Anon
  - Intervention Options
  - Explore Cultural and Generational sources of resistance
  - Discuss financial control options
  - Discuss intervention options

Case Study: Mom

- Children never come back
- Mom never presented to treatment
- Outcome not known
- Further outreach not offered or extended

Lessons Learned

- How to engage the disengaged?
- Children did not like the focus being on them, wanted to talk about mom
- What options truly exist for financial control or restraint?
- Importance of unified approach

Surgeon's Wife

Surgeon's Wife

- Ellen contacts for intake appointment after Internet search
- Requests information on how to deal with husband's gambling and infidelity
- Knows about Gam-Anon, SA and has her own therapist already but seeks "expert consultation"

Surgeon's Wife

- Married 19 years
- 2 children, 12, 15
- She is a physician
- Husband is a surgeon (orthopedics)
- They live in Newport Beach

Surgeon's Wife

- She describes a pattern on escalating sexual practices since marriage began
  - Conventional to unconventional
  - Porn to sex toys to swinger parties to voyeuristic fantasies
- She complies out of "wifely duties"
  - Never felt connected to behaviors

Surgeon's Wife

- 3 years ago, husband begins an obvious, intimate affair with a co-worker
  - Weekends / trips away from family
  - Sex life goes to zero
  - Verbally aggressive but not abusive
  - She also discovers gambling debt

Surgeon's Wife

- Family life deteriorates despite her efforts
  - Asks him to go couples counseling
  - She seeks her own therapist
  - Children are insulated
  - No one outside of the family knows about this
  - Appearances are kept

Surgeon's Wife

- Tipping point comes when wife realizes he has lost over $250,000 in 2 years and that his / their retirement funds are exhausted
- Escalating conflicts
- She decides to make a move toward separation but doesn't know what the first step is.

Surgeon's Wife

- Her current therapist tells her
  - Go to Gam-Anon
  - Change the locks
  - Go through divorce
    - Seek full custody of children
  - Restart her career

Surgeon's Wife

- Additional tools for her to consider
  - Medications for her?
  - Focus on her own recovery activities
    - Building social capital
    - Hiring additional support staff
    - Truly shielding her assets / resources
    - Educating about disease course
    - What to actually tell the children

Summary

- Gambling disorder and hypersexual behaviors are common enough to warrant screening at all times
- Tools and techniques exist but most have never been properly tested
- Principles of recovery apply

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