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HIV/AIDS 5 hr. UPDATE

HIV/AIDS Statistical Update

In the United States, CDC estimates that 1,178,350 persons were living with HIV at the end of 2008, with 594,496 having died from AIDS since 1981.
Thirty years after that first report, the most recent estimate is that 33.3 million persons were living with HIV infection & 1.1 million are Americans.

11/29/11 Vital Signs report & fact sheet
Nearly 1 in 5 people with HIV (or 240,000 people) don't know they are infected.
People who don't know are at higher risk of serious medical problems and early death.
Only 41% of people with HIV get ongoing HIV medical care.
Only 28% of people with HIV have viral suppression.
Viral suppression improves health, extends life, and can help to prevent people from transmitting the virus to others.

Why HIV/AIDS Statistical Update?
Estimated 56,300 new cases a year in the U.S.
More than 18,000 people die every year in the U.S.
1 person infected every 9 min's in the U.S.
Black account for 12% of the total U.S. population but make up roughly ½ of the new

AIDS UPDATE:
A = Acquired = a virus received from someone else.
I = Immune = individual's natural protection against disease-causing microorganisms.
D = Deficiency = a deterioration of the immune system.
S = Syndrome = a group of signs and symptoms that together define AIDS as a human disease.

Cost of HAART
Seven Protease Inhibitors in Use and Cost.

Invirase	- $440.00 per month	Fortovase	- $250.00 per month
Norvir	- $750.00 per month	Crixivan	- $525.00 per month
Viracept	- $725.00 per month	Reyataz	- $830.00 per month
Lexiva	- $650.00 per month		

By Transmission Category
In 2008, the largest estimated proportion of HIV/AIDS diagnoses among adults and adolescents were for men who have sex with men (MSM), followed by persons infected through heterosexual contact.

By Age
In 2008, persons aged 25–34 and persons aged 35–44 accounted for the largest proportions of newly diagnosed HIV/AIDS cases.
New estimates for yearly infection of HIV in the U.S. went from 40,000 per year to between 58,000 to 60,000 new cases per year.

HIV/AIDS in People over 50
Thirty years into the pandemic AIDS is increasingly a disease of older people who make up one of the fastest growing segments of the HIV positive population.
Of the estimated 1.1 million Americans with HIV, some 407,000 are over 50: by 2017 half of the total HIV positive population will be over 50.

Shockingly, one in seven new diagnoses of HIV or AIDS is in a person over 50.
The health care system will feel the impact since older people with HIV contract more disease of aging than their uninfected peers.
Though HIV is often transmitted by sharing needles, older American are more likely to get it through unprotected sex.

Many think condoms are only for preventing pregnancies.
Other's think a partner over 50 is less likely to have the disease.
There is a concern that improved treatments feed a sense of complacency about HIV, particularly among women.
Most women don't feel they are at risk???

HIV/AIDS Statistics
In 2009, there were an estimated 11,200 new HIV infections among women in the United States. That year, women comprised 51% of the US population and 23% of those newly infected with HIV.

Of the total number of new HIV infections in US women in 2009, 57% occurred in blacks, 21% were in whites, and 16% were in Hispanics/Latinas.

In 2009, the rate of new HIV infections among black women was 15 times that of white women, and over 3 times the rate among Hispanic/Latina women.

At some point in her lifetime, 1 in 139 women will be diagnosed with HIV infection. Black and Hispanic/Latina women are at increased risk of being diagnosed with HIV infection (1 in 32 black women and 1 in 106 Hispanic/Latina women will be diagnosed with HIV, compared with 1 in 182 Native Hawaiian/other Pacific Islander women; 1 in

217 American Indian/Alaska Native women; and 1 in 526 for both white and Asian women).

From 2006 through 2009, estimated diagnoses of HIV infection among women decreased from 10,851 to 9,973. It is unknown whether this decrease is due to an actual decrease in new HIV infections (incidence) or whether the decrease reflects HIV testing trends.

Women accounted for more than 25% of the estimated 34,247 AIDS diagnoses in 2009 and represent nearly 20% of cumulative AIDS diagnoses (including children) in the United States to date. There were 8,647 AIDS diagnoses among women in 2009 compared with 9,639 AIDS diagnoses among women in 2006.

For women living with a diagnosis of HIV infection, the most common methods of transmission was heterosexual contact and injection drug use.

In 2008, 4,796 (28%) of the estimated 17,374 persons with a diagnosis of HIV infection who died in the 40 states and 5 US dependent areas were women. Deaths attributed to HIV among women of color are disproportionately high: from 2000–2007, HIV infection was among the top 10 leading causes of death for black females aged 10–54 and Hispanic/Latina females aged 15–54.

Prevention Challenges
Like other affected populations, women face a number of risk factors that may contribute to their risk for HIV infection.

Most women are infected with HIV through heterosexual sex. Some women become infected because they may be unaware of a male partner's risk factors for HIV infection or have a lack of HIV knowledge and lower perception of risk. Relationship dynamics also play a role. For example, some women may not insist on condom use because they fear that their partner will physically abuse or leave them.

Both unprotected vaginal and anal sex pose a risk for HIV transmission. Unprotected anal sex presents an even greater risk for HIV transmission for women than unprotected vaginal sex.

Women who have experienced sexual abuse may be more likely than women with no abuse history to use drugs as a coping mechanism, have difficulty refusing unwanted sex, exchange sex for drugs, or engage in high-risk sexual activities.

Socioeconomic issues associated with poverty, including limited access to high-quality health care; the exchange of sex for drugs, money, or to meet other needs; and higher levels of substance use can directly or indirectly increase HIV risk factors.

HIV STATS
Substance use in Patients with HIV/AIDS

Informational work by AIDS Institute of New York State Department of Health 2009

Editing and Production by John Hopkins University School of Medicine Division of Infectious Diseases

INTRODUCTION
What are these drugs?
The following is some of the more commonly used substances with a brief explanation of how and why people use them and some of the negative consequences of people living with HIV/AIDS.

Benzodiazepines
What are they?
Sedatives often prescribed for anxiety, panic attacks and insomnia.
For illicit use, may be obtained on the streets or from physicians.
High potency formulations such as Alprazolam and Clonazepam are often most sought after.

Street names; Benzos – Downers – Sticks
How are they used? Orally
Why do people use them;
Reduce anxiety
Cause sedation
Enhance the effects of other depressants
Offset the side effects of stimulants

Acute effects;
Sedation – Ataxia – psychomotor retardation – drowsiness – memory impairment – disinhibition – respiratory depression
Chronic effects;
May worsen depression

Withdrawal;
Anxiety, insomnia, tremulousness, headache
Seizures and death can occur
In some cases, withdrawal is very similar to that seen in alcohol dependence
There may be a prolonged withdrawal syndrome characterized by insomnia, anxiety, and sensory hypersensitivity, which may contribute to inability to maintain abstinence

Pregnancy/Fetal issues;
Sedation
"Floppy baby syndrome"
Dependence with withdrawal signs, including hypertonia, restlessness, irritability, and possibly seizures

Comments:

Benzodiazepine misuse is common among methadone patients and contributes to the nodding observed in some patients.
Benzodiazepines are also frequently implicated in mixed-drug overdoses.

Cocaine
What is it?
Derived from the coca plant
Two principal forms: powder (cocaine hydrochloride) and solid ("crack" or "base")
Crack cocaine has a more rapid and intense effect, but both forms are the same drug with the same physiology.

Street Names:
Coke - Nose candy - Rock - Blow - Crack

How is it used?
"Powder" cocaine is usually sniffed or dissolved in water and injected
Crack cocaine is usually smoked. Some people inject it after first dissolving it in an acidic solution (like vitamin C or lemon juice)
When smoked or injected, the euphoria (rush) is rapid, intense, and short lived (3-10 minutes); may last up to 30 minutes when sniffed.

Why do people do it?
Euphoria
Increased sexual interest
Alertness
confidence

Acute Effects:
Increased heart rate and blood pressure
Loss of appetite
Anxiety with paranoid ideation
Lowered seizure threshold
Arrhythmias
Vasospasm, which may lead to myocardial infarction or cerebral vascular accident
Hyperthermia, which can be fatal
Extreme dysphoria and despondency often follow the euphoria, leading users to binge
Chronic Effects:
Weight loss
Dysphoria
Depression
Nasal perforation
Accelerated HIV disease progression

Withdrawal:
No physical syndrome of withdrawal but craving for more cocaine can be intense

Pregnancy/Fetal issues:
Risk of spontaneous abortion, premature labor, abruptio placenta, and low birth weight
Debate in the literature over long-term effects on development, but most studies have not found a strong effect
Reduced placental blood flow
Intrauterine fetal growth restriction
Fetal cerebrovascular incident

Comments:
Under federal law, possession of >5 grams of crack cocaine of >500 grams of powder carries a mandatory penalty of 5 years in prison

Marijuana
What is it?
Derived from the flowers and leaves of the Cannabis sativa plant
Hashish is the concentrated resin
Primary active ingredient is ^9-THC, but a number of other chemicals are believed to have a role in its effects
Cannabinoids act on receptors that also respond to endogenous CNS ligands

Street names; Pot – Weed – Reefer – Dope – Joint – Blunt

How is it used?
Smoked or ingested orally buy mixing marijuana in brownie mix or sautéing in butter or oil before frying foods

Why do people use it?
Euphoria
Relaxation
Perceptual alterations
Intensification of sensory experiences

Acute effects;
Increased heart rate
Impairment of short-term memory and motor skills
Increased appetite
Conjunctival injection
Sometimes anxiety and panic

Chronic effects;
Cannabis smokers may be at increased risk for chronic bronchitis and respiratory cancers
Most studies have not found any irreversible long-term effects on cognition, although debate continues
The possibility that use of marijuana at a young age raises the risk of schizophrenia is also under debate

Withdrawal
Sleep and appetite disorders
Irritability and anxiety sometimes accompany abrupt cessation of chronic marijuana use

Pregnancy/Fetal issues:
No evidence of fetal malformations
Various inconsistent results include associations with lower birth weight and childhood cancers
Placental vascular abnormalities
Intrauterine fetal growth restriction

Comments
Medically, marijuana has been found to increase appetite, reduce nausea, and relieve pain. Debate continues on efficacy and risk in comparison with other medications

MDMA (Ecstasy)
What is it?
MDMA is a synthetic analogue of amphetamine
Street names: Ecstasy – E – X
How is it used?
Ingested orally, intranasally, and sometime injected
Effects last 3 to 5 hours per dose

Why do people us it?
Euphoria - Sensory enhancement - Empathy - Energy - Sexual charge - Sexual conquest

Acute effects:
Increased heart rate, tremor, anorexia, anxiety, dry mouth
Rarely: seizures, hyperthermia leading to disseminated intravascular coagulation (DIC), and organ failure
MDMA users are often advised to stay well hydrated; however, consuming large amounts of hypotonic fluids with MDMA has been documented to lead to hyponatremia (MDMA increases release of antidiuretic hormone)

Chronic effects:
Long-term damage to serotoninergic neurons in the animal studies, but this has not been clearly shown in humans
Anecdotal evidence that chronic use leads to depression

Withdrawal:
No withdrawal syndrome, but some people use it compulsively
Pregnancy/Fetal issues:
No data which controls for other variables

Comments:

MDMA was first synthesized in 1912 and was used in psychotherapy in the 1970's.
Recreational use began in the 1980's at which point it was classified as Schedule 1
The FDA has approved a research protocol on the use of MDMA in post-traumatic stress disorder

Opiates

What are they?
Originally derived from the poppy plant although there are now also semi-synthetic (e.g. heroine) and synthetic (e.g. methadone) classes
Most commonly used to treat severe or chronic pain
For illicit use, may be obtained on the street or from physicians
High potency formulations such as OxyContin® are often most sought after

Street names
Dope – smack – junk – horse – Manteca
Generally sold in $10 bags, 10 of which make a bundle

How are they used?
Orally, nasally inhaled, smoked, injected intravenously or subcutaneously
Why do people use them?
Opiates reduce pain, but opiate abusers experience feelings of sedation, euphoria, analgesia, and a "rush"

Acute effects:
Sedation, euphoria
Respiratory depression
Decrease in blood pressure and heart rate
Noncardiogenic pulmonary edema has been associated with acute opiate use

Chronic effects:
Many of the medical consequences of opiate use are effects of the route of administration and not the drug itself
Injection can lead to endocarditis, abscess formation, clots, skin tracks, and scarring
Infected needles can transmit hepatitis B and C, and HIV infection.

Withdrawal:
Can be divided into early, middle, and late phases:
Early: yawning, sweating teary eyes, and runny nose.
Middle: restless sleep dilated pupils, goose-flesh, tremor, irritability
Late: an increase in all early and middle signs and symptoms with an increase in blood pressure, nausea, vomiting, diarrhea, abdominal cramps, labile mood, depression, muscle spasm, weakness, and bone pain.
Heroin withdrawal usually starts 8-12 hours after the last use and peaks at 48 hours, lasting from 5-10 days
Methadone withdrawal generally begins 24-48 hours after the last dose; it is somewhat more gradual in onset but lasts several weeks

Pregnancy:
If a woman who is dependent on opioids becomes pregnant, the clinician should discuss treatment options with her, informing her that methadone maintenance is preferred to detoxification with its attendant risks of withdrawal and relapse
Opiate withdrawal during pregnancy can lead to spontaneous abortion or premature labor

Alcohol
What is it?
Ethanol, derived from a variety of plant sources
How is it use?
Oral ingestion

Why do people do it?
To feel pleasure, relax, decrease anxiety and sexual inhibition
Among persons with alcohol dependence, alcohol is ingested to avert uncomfortable withdrawal symptoms.

Acute effects:
Signs and symptoms of alcohol intoxication (increased severity according to amount of alcohol consumed):
Diminished muscular coordination - Confusion - nausea, vomiting, diplopia, sluggish pupils - hypothermia - cold sweats - stupor - amnesia (alcohol related black outs) - Risk of coma

Chronic effects:
Nervous system – insomnia, anxiety, cerebellar dysfunction, optic neuropathy, peripheral neuropathy, seizures
Cardiac – arrhythmia, cardiomyopathy, worsening hypertension
Hepatic – fatty liver, hepatitis, cirrhosis with complications (e.g. testicular atrophy, ascites, varices, encephalopathy, gastrointestinal – gastritis, peptic ulcer disease, pancreatitis
Musculoskeletal – myopathy, osteoporosis
Metabolic – chronic malnutrition, vitamin deficiencies, including thiamine, folate, and vitamin B12
Dermatologic complications
Hematologic / Immunologic – anemia thrombocytopenia, decreased WBC function
Cancer – increased risk of cancer of the liver, pancreas, mouth, tongue, pharynx, larynx, and esophagus

Withdrawal:
Occurs 6-60 hours after last drink
Manifested by tremors, sweats, flush, anxiety, insomnia, anorexia, nightmares, diarrhea, nausea, vomiting, aches, abdominal cramps, restlessness, and elevated vital signs
Withdrawal can last 3-5 days

Major withdrawal (DT's) is manifested by confusion; markedly elevated vital signs; agitation, often with belligerence; pronounced tremor; diaphoresis; and hallucinations. Even if treated, mortality is between 1% and 3%.
Withdrawal seizures are usually isolated, although can be recurrent (25%)
Withdrawal can last 3-5 days
Persistent mile withdrawal consists of sleep disturbances, mild tremors, anxiety, and depression and can last for several weeks to months.
Treatment of withdrawal consists of bensodiazepine

Pregnancy/Fetal issues:
In the United States, 1 in 300-1000 births have fetal alcohol syndrome or fetal alcohol effect. Hallmarks of fetal alcohol syndrome include:
Fetal growth retardation
Facial dysmorphism
Central nervous system dysfunction

Comments:
Pharmacologic treatments for alcohol dependence and to help prevent relapse include:
Disulfiram: causes aversive symptoms if alcohol is ingested
Naltrexone (oral or injectable): opioid antagonist that blunts the pleasurable effects of craving for alcohol

Ketamine
What is it?
Ketamine hydrochloride
Developed as an animal anesthetic
Dissociative anesthetic similar to PCP

Street names
K - Vitamin K – Special K – A K-hole is a deeply dissociated state

How is it used?
Smoked, intravenously, orally, inhaled

Why do people use it"
One of the "Club Drugs"
Hallucinogen-like, visual illusions, distortion of body image

Acute Effects
Increase in blood pressure, hallucinations, anxiety, muscle rigidity, feelings of strength and special insights
Impaired motor skills, judgment, and speech

Chronic effects
Protracted psychosis similar to that seen with PCP
Withdrawal

None, craving can develop

Pregnancy/Fetal issues
Neuronal cell death in the fetus seen in experimental studies

Acute effects
Mild euphoria, relaxation; at high levels: loss of consciousness, seizures, vomiting

Chronic effects
Tolerance and dependency

Withdrawal
1-6 hours after use: anxiety, restlessness, insomnia, tremor, confusion, delirium, hallucinations, tachycardia, elevated BP, nausea, and vomiting

GHB
What is it?
Gammahydroxybutyrate (similar to sedatives)
Developed as an anesthetic

Street names
Liquid ecstasy, Grievous bodily harm

How is it used?
Clear liquid, powder, or pill most often taken orally
Why do people use it?
Mild euphoria
Body builders use it to build muscles (growth hormone release)

Pregnancy/Fetal issues
Little known

Comments
Effects of any dose are very unpredictable

Number one of the top 4 drugs used in drug facilitated sexual assault in both gay and straight communities.
High risk for drug facilitated assault in bars, parties, proms, or home environment.

Methamphetamine
What is it?
Synthetic stimulant similar to cocaine but with longer period of effect
Street names: Crystal, Tina, Speed, Crank

How is it used?

Orally, intravenously, smoked intranasally, rectally

Why do people use it?
Weight loss
Reduced fatigue, sustained alertness
"Rush" and energy
Increased interest in sex

Acute effects
Smoking can produce a high of 7-24 hours in duration
Increased energy and alertness, elevated mood, dilated pupils, increased heart rate and blood pressure, decreased appetite, tremors, sweats, headache

Chronic effects
Psychosis, depression
Memory loss
Dependence
Insomnia
Tolerance (develops in several weeks)
Damage to dopamine- and serotonin-containing neuron terminals
Methamphetamine

Withdrawal
Extreme fatigue ("crash effect")
Depression
paranoia

Pregnancy/Fetal issues
Neonatal behavior problems (hyper-irritable, poor feeding, lethargy)
Increased in placental abruptions
Reduced gestational age
Low birth weight, length, and head circumference
Reduced placental blood flow
Intrauterine fetal growth restriction
Fetal cerebrovascular incident

Comments
Use has spread from the west coast to the US to the east, particularly among MSM where it is associated with high-risk sexual activity

Anabolic-Androgenic Steroids
What are they?
A class of steroid hormones related to testosterone
Street names – Arnolds – stackers – gym candy – weight trainers – pumpers – juice – roids – sticks

How are they used?
Orally, injected, or transdermally (relating to, being, or supplying a medication in a form for absorption through unbroken skin into the bloodstream)

Why do people use them?
Legally prescribed to treat body wasting and endocrine disorders
Athletes misuse for enhanced performance
Others misuse for improved physical appearance

Short-term effects
Increased muscle mass and strength when combined with training

Chronic effects
For men:
Testicular atrophy, reduced sperm count

For women:
Changes in menstrual cycle
Anabolic-Androgenic Steriods

For both
Severe acne
Mood swings, association with aggression
Potential liver damage, increases in LDL and decreases in HDL
High blood pressure

Withdrawal
Rare
Mood swings, depression, fatigue, restlessness, loss of appetite, insomnia, reduced sex drive and steroid cravings

Pregnancy/Fetal issues
Can cause development of male features in the female fetus and female features in the male fetus.
Can cause physical stunt growth in both male and female youth
Comments
Prevalence of adverse effects unclear

HIV & SEXUAL ADDICTION

SEXUAL ADDICTION
Sexual Compulsivity
Sexual Dependency
Sexual Drive Disorder
Sexual Impulse Control Disorder
Male Sex Trade Workers

Female Sex Trade Workers

NO MATTER WHAT YOU CALL IT IT'S A PROBLEM!

Male street workers and internet escorts having sex with men reported high HIV RISK: Research has found that over four of ten seropositive sex workers were unaware of their infection. Men engaging in sex work with other men were more likely to engage in unprotected sex with male and female nonsex work partners. Hence, these men may be an important "bridge" of HIV/STI to nonsex work partners. Journal of Urban Health, 86, 54-66. (2009)

Methodology:
Two groups of sex workers (street workers, n=19; internet escorts n=13) were Recruited in the Boston, MA area, January to March 2008.

Outcomes of the Study:
63% white
16% Black/African American
19% Hispanic/Latino
21% Other
Mean age was 28 for internet escorts and 43 for street workers. Street workers had less education.

Major findings include:
31% HIV infected
69% reported at least one episode of unprotected serodiscordant anal sex (either insertive or receptive) with a mean of 11 male sex partners of unknown or different HIV serostatus in past 12 months.

Substance abuse used during sex:

75% marijuana	53% cocaine
31% crack	22% crystal meth
22% Viagra (nonprescribed)	22% painkillers
19% poppers	16% ecstasy
16% downers	09% GHB
06% ketamine	03% hallucinogens
03% heroin	

33% had a history of depression and 41% reported a history of child sexual abuse.
Inconsistent condom use, unprotected sex, low rates of HIV status disclosure were found for both groups.
Offers of money for unprotected sex were made
25% of both groups had never been tested for STI's.
There was a lack of trust on the part of sex work partners
Internet sex workers reported that they were more likely to engage in sexual risk taking with nonsex workers partners than sex partners who pay.

Sex and the Internet:
Women are now on-line more than men.
50% of the people on-line lie about their age, weight, job, marital status and gender.
20% of the people going on-line will experience clear negative impacts to their life.
Use of the Internet is a contributing factor in nearly 50% of all family, relationship, and family problems.
11% of the people going on-line are becoming compulsive or addicted to porn.

Unique Internet Aspects that might Fuel Addiction:
The Sextruple A Engine – Anonymous – Accessible - Accelerated – Acceptance – Approximation

Additional Factors that Contribute to Addiction,
Use, Abuse
Disinhibition – Intensity – Stimulating – Hypnotic – One-Stop shopping – Effective and FAST stress and boredom relief – Fantasy replaces reality.

CYBERSEX: The crack cocaine of sex addiction (Carnes)
Types of cybersex activities:

Chatting about sexual fantasies, self-stimulation and masturbation, real time viewing of each other's bodies using web cams, watching live sex shows broadcast online in real time, viewing online pornographic images, pain exchange as part of activity, phone sex with people met through the internet, subscriptions to adult newsgroups, going to meet a person they met online to further the cyber affair, buying sex on the internet, grooming and exploiting victims.

Cycle of Addiction
1. Obsession - The addict loses the ability to concentrate on daily life as his mind becomes saturated on how he or she will obtain relief. The trigger can be anger, shame, pain, anxiety, poor-me obsession with hurts, or a form of pornography."
2. The Hunt - The addictive craving is driven to action.
3. Recruitment - Identify and obtaining a "victim"-pornographic magazines, peep show, enticing unsuspecting person.
4. Gratification - Finding the right kind of pornography, or the right kind of partner, or the right brand of perverse sexual behavior is what fuels the addictive process from one level to the next.
5. Return to "Normal" - Usually the relief/release is only temporary. Relapses are almost certain to occur.
6. Self-Justification - Self-talk such as "No one was hurt, it was really OK, and everyone does it."
7. Blame - Scapegoats someone (parents, society, God, etc.) for the dreadful feelings instead of accepting responsibility
8. Shame - Recognition of the shame of the addiction
9. Despair - Finally, the pain of acting out the addiction is greater than the despair.
10. Resort to other addictions - Healthy or unhealthy

11. Promises - Never to do it again.
Sexual addiction can build tolerances to ever-growing quantities which produce ever-diminishing returns of relief.
It produces withdrawal symptoms.
It is an obsessive-compulsive response to trauma, loss of control, failure of coping mechanisms, etc.

As the obsession turns to compulsion, the addict finds himself, as in any other addiction, in the act of doing things he doesn't want to do, things he promised never to do again. It is as though he is standing outside himself, pleading with himself not to go on, but acts by the draw of the addiction.

Characteristics of Sexual Addiction
Done in isolation
Secretive
Impersonalizes sex
Detachment
Double Life-A "public" and "private" self
Addict devoid of authentic interaction
May have victims (children and/or adults)
Leaves addict with greater guilt, emptiness, shame and despair.

Levels of HIV & SEXUAL ADDICTION
Level I: The self-deceiving "not that bad" things--fantasy, pornography (magazines, video, cable TV, Internet, etc.), masturbation.
Level II: Satisfying the obsessive craving-live pornography, nude dancing, affairs, fetishes, phone sex, inappropriate "accidentally on purpose" touching.
Level III: Criminal Activities-prostitution, "casual" and "intentional" voyeurism and exhibitionism.
Level IV: Severe Criminal Consequences-child molestation, sexual assault, rape.

FAMILY OF ORIGIN:
1. Come from severely dysfunctional families.
2. 87% have another addiction of some type in the family.
3. Were confused about family roles, rules and boundaries.
4. Experienced abandonment “events,” such as divorce, death or being orphaned.
5. Were discredited or judged as a child by a family member.
6. Experienced a fundamental failure to bond.
7. Come from rigid disengaged families.

VICTIMIZATION:
1. Are victims of some form of abuse:
    - 97% emotionally abused
    - 81% sexually abused
    - 73% physically abused
2. Deny and repress their abuse experiences.

3. Have developed high tolerance for pain.
4. See humiliation, degradation and shame (especially as related to sexual behavior) as normal due to their victimization.

SELF:
Perceive themselves as flawed, bad or evil, often as a conclusion of family messages.
2. 83% have more than one addiction.
3. Have characteristics of Adult Children of Alcoholics.
4. 71% contemplated suicide or faced severe depression.
5. Are super-achievers or underachievers -- live in the extremes.

TRAITS:
Studies reveal that sexual addicts often possess many of the following behavior traits.
1. Use sexual humor.
2. Dress inappropriately.
3. Possess seductively or charm.
4. Have patterns of short-term relationships.
5. Are not accountable for time or money.
6. Moralize or express religiosity.
7. Live on the edge/in the extremes.
8. Are emotionally remote/distant.
9. Are super-achievers or under achievers
10. Are compulsively busy.
11. Have physical problems with sex.
12. Abuse self especially with sex and the dangers involved.

MOOD ALTERATION:
1. Found sex as a solution early in life.
2. Use sexual obsession and fantasy as a primary coping strategy.
3. Use sex as a medication for sleep disorders, anxiety, physical pain, family, and life problems.
4. Use medical language to describe sexual behavior as a pain or tension reliever.
5. Escalate their sexual behavior during most stressful moments of work and family life.
6. 89% experience pain and sadness alternating with sexual highs to the point of emotional exhaustion.

CONSEQUENCES:
1. Recall near death experiences from violence, jeopardy situations, accidents or rape.
2. Recognize AIDS as the most lethal form of complication to their illness.
3. 40% lose a partner or spouse.
4. 70% experience sever marital or relationship problems.
5. 13% lose rights to their children.
6. 8% can no longer be with their family of origin.
7. 58% face severe financial consequences to their addition.

8. 27% report loss of opportunity to work in the career of their choice.
9. Speak of serious losses of job, productivity or position.

EFFORTS TO CONTROL:
1. Use excessive religiosity to control behavior.
2. Move or change jobs to start over.
3. Sought therapy but were ridiculed, disbelieved or sexually abused before finding competent help.
4. 71% experience periods of sexual "anorexia" where all sexual urges and behaviors are tightly controlled.
5. Self-mutilate or otherwise abuse self to prevent further sexual behavior.
6. Make promises to self to quit addictive sexual behavior.
7. Attempt to slow down their sexual behavior.

SEXUALITY:
1. Experience extreme sexual shame, believing they are bad for having sexual feelings.
2. Operate with the rule that "for sex to be good, it has to be bad," making sinful or illicit activities supercharged.
3. Experienced negative religious messages which intensely reinforced their negative sexual self-image.
4. Have significant distortions, myths and dysfunctional beliefs about sex and are in desperate need of basic sex information.
5. Connect sex with survival, believing sex is their most important need.
6. Tend to sexualize all nurturing and have few or no non-sexual relationships.
7. Experience some degree of gender hatred, either for the same or opposite sex.
8. Never experienced themselves sexually as a whole person despite incredible amounts of sexual behavior.

CURRENT RELATIONSHIPS:
1. Have stormy and unsuccessful long-term relationships.
2. Have patterns of short-term relationships, both personal and professional.
3. Leave interpersonal transactions unfinished and relationships upended.
Search for people who will take care of their neediness and to be vulnerable and dependent on them.
5. Are unaccountable for money or time in any relationships.
6. Are emotionally absent, especially at critical times, due to shame surrounding their double life.
7. Have little or no history of successful intimacy.
8. Have characteristics of a co-dependent personality disorder.

OUT OF CONTROL BEHAVIOR:
1. Identify immediately with the term "sexual addiction."
2. Go through a painful process to acknowledge their behavior.
3. Spend extreme amounts of time obtaining sex, being sexual, or recovering from sexual experiences.

4. Exceed their intent in the amount, type, extent and duration of sexual behavior.
5. Experience escalating patterns of sexual behavior when level of activity no longer sufficient.
6. Sacrifice important social, occupation and recreational activities because of sexual behavior.
7. Pursue sexual behavior despite obvious risk and danger.
8. Pursue their behaviors repetitively to the point of physical injury (38%) or exhaustion (59%).
9. Lead a secret or double life.
10. 65% run the risk of venereal infections, HIV/AIDS because of no precautions.
11. 85% have engaged in activities for which they could have been arrested.
12. 29% is the average for arrest.

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