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Author's Reply

We agree with Nathan Hodson and Susan Bewley that the social exclusion of people with severe mental illness is associated with intimate partner and sexual violence as an important factor among others that contribute to HIV risk behaviours. Even without the presence of violence, mental illness stigma, and especially “relationship discrimination” stigma has been shown to be associated with HIV sexual risk behaviours.[1,2]

TasP or treatment as prevention not only suppresses viral load for public health purposes,[3] it also provides people with HIV the freedom to refocus their sexual lives away from a sick vector role and view it as a healthy activity. Thus, both those with HIV with undetectable viral loads and their sexual partners benefit from TasP. TasP can facilitate the destigmatisation of people living with HIV.

The main point of our Comment is that the existing global efforts to end HIV, hepatitis B virus, and hepatitis C virus are not reaching people with severe mental illness; public psychiatric care systems stigmatise their patients by not participating in these efforts. Although probably unintended, that can be considered an iatrogenic health-care system stigma against people with severe mental illness and their sexual partners.

We declare no competing interests.

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Data do not support sex as addictive

Marc Potenza and colleagues[1] advocated classifying “excessive sexual behaviour” as an addictive disorder in ICD-11. Sex has components of liking and wanting that share neural systems with many other motivated behaviours.[2] However, experimental studies do not support key elements of addiction such as escalation of use, difficulty regulating urges, negative effects, reward deficiency syndrome, withdrawal syndrome with cessation, tolerance, or enhanced late positive potentials. A key neurobiological feature of addiction is the increased responsiveness of glutamate neurons that synapse on the nucleus accumbens. These changes might affect long-term sensitisation of the mesocorticolimbic dopamine pathway, as manifested by a range of symptoms including cue-induced craving and compulsive drug use.[3] To date, research on the effects of sex on glutamate function and its modulation of dopamine pathways is scarce.

Sex is a primary reward, with unique peripheral representation. Engagement in sex is positively associated with health and life satisfaction. Sex does not allow for supraphysiological stimulation. Research in this area has yet to investigate actual partnered sexual behaviours. Experimental work has been limited to sexual cues, or secondary rewards, using images.

More research is needed, but data concerning frequent or excessive sex do not support its inclusion as an addiction. Also, data are not sufficient to differentiate between compulsive and impulsive models. Many other approaches exist, including well-supported non-pathological models.[4] Potenza and colleagues[5] also stated that addiction criteria were not met for sexual behaviours: we agree with this earlier conclusion.

We declare no competing interests.

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