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What should be included in the criteria for compulsive sexual behavior disorder?

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Debate: Behavioral addictions in the ICD-11

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DEBATE PAPER



ABSTRACT

Compulsive sexual behavior disorder (CSBD) is currently defined in the eleventh revision of the International Classification of Diseases (ICD-11) as an impulse control disorder. Criteria for hypersexual disorder (HD) had been proposed in 2010 for the fifth revision of Diagnostic and Statistical Manual (DSM-5). In this article, we compare differences between HD and CSBD and discuss their relevance.

Significant differences between HD and CSBD criteria include: (1) the role of sexual behavior as a maladaptive coping and emotion regulation strategy listed in criteria for HD but not in those for CSBD; (2) different exclusionary criteria including bipolar and substance use disorders in HD but not in CSBD, and (3) inclusion of new considerations in CSBD, such as moral incongruence (as an exclusion criterion), and diminished pleasure from sexual activity. Each of these aspects has clinical and research-related implications. The inclusion of CSBD in the ICD-11 will have a significant impact on clinical practice and research. Researchers should continue to investigate core and related features of CSBD, including those not included in the current criteria, in order to provide additional insight into the disorder and to help promote clinical advances.

KEYWORDS

compulsive sexual behavior disorder, hypersexual disorder, ICD-11, diagnostic criteria

COMPULSIVE SEXUAL BEHAVIOR DISORDER (CSBD) IN THE ICD-11

Compulsive sexual behavior disorder (CSBD) is currently defined in the eleventh revision of the International Classification of Diseases (ICD-11; WHO, 2020; Kraus et al., 2018) as an impulse control disorder and “characterized by a persistent pattern of failure to control intense, repetitive sexual urges and behaviors” where an individual (1) devotes excessive time to sexual activities to the point of neglecting health, personal care, interests, and responsibilities, (2) experiences diminished control manifest by multiple unsuccessful efforts to reduce sexual behavior, (3) continues sexual activity despite adverse consequences, (4) continues engagement in sexual behavior even when little or no satisfaction is derived, and

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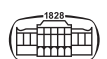
(5) experiences significant distress or impairment across life domains or important areas of functioning. The classification also cautions, “Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviors is not sufficient to meet this requirement.” Additionally, paraphilic disorders are exclusionary. The ICD-11 definition shares similarities with the proposed criteria for hypersexual disorder (HD) that was considered, but ultimately excluded from the DSM-5 (American Psychiatric Association, 2013; Kafka, 2010, 2014), with several notable differences relating to (1) emotion and/or stress-regulation-related features, (2) moral incongruence related to sexual behaviors, (3) problematic sexual behaviors related to substance use, and (4) less satisfaction from sexual activities (Table 1).

EMOTION DYSREGULATION AND MALADAPTIVE COPING

Emotion-regulation-related symptoms are not included in criteria for CSBD in the ICD-11 despite data showing CSB is often associated with using sex to cope with difficult emotions (e.g., sadness, shame, loneliness, boredom, or anger), stress or painful experiences (Lew-Starowicz, Lewczuk, Nowakowska, Kraus, & Gola, 2020; Reid, Carpenter, Spackman, & Willes, 2008; Reid, Stein, & Carpenter, 2011). In the conceptualization of HD proposed by Kafka (2010) for DSM-5, two of five criteria directly address the use of sexual activities to regulate emotion or reduce stress (A2 and A3, Table 1).

Table 1. Comparison of compulsive sexual behavior disorder conceptualization proposed for ICD-11 and hypersexual disorder proposed for DSM-5

Compulsive sexual behavior disorder proposed for ICD-11	Hypersexual disorder proposed for DSM-5	Domain
1. Repetitive sexual activities become a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities	A1. Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other important (non-sexual) goals, activities and obligations.	Domain: Excessive focus and amount of time dedicated to sexual behavior to the point of neglecting other important life domains.
2. A person makes numerous unsuccessful efforts to significantly reduce repetitive sexual behavior	A4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviors.	Domain: Impaired control.
3. The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behavior causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.	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 or behaviors.	Domain: Sexual thoughts or behavior generating marked or significant distress and/or impairment in functioning.
4. A person continues the engagement in repetitive sexual behavior despite adverse consequences.	A5. Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.	Domain: Continued engagement in sexual behaviors despite risk and/or adverse consequences
5. A person continues the engagement in repetitive sexual behavior despite deriving little or no satisfaction from it	Not present	Domain: Compulsive engagement involving less sexual satisfaction over time.
Not present	A2. Repetitively engaging in sexual fantasies, urges or behaviors in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).	Domain: Using sexual behavior as a maladaptive coping strategy in response to unpleasant emotional states or stress
Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviors is not sufficient for a CSBD diagnosis.	A3. Repetitively engaging in sexual fantasies, urges or behaviors in response to stressful life events.	Exclusion criterion: distress entirely related to moral incongruence
Not present	Not present	
	C. These sexual fantasies, urges or behaviors are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication).	Exclusion criterion: CSBD episodes directly due to exogenous substances



Emotional dysregulation has been related to hypersexuality in clinical contexts and conceptual and theoretical models (Carnes, 2001; Kingston & Firestone, 2008; Wéry & Billieux, 2017). Goodman's model had 3 main constituents: impaired affect regulation, impaired inhibition of behaviour, and aberrancies in the functioning of motivational reward systems (Goodman, 1997). In conceptualizing hypersexuality and developing the Hypersexual Behavior Inventory (Reid, Garos, & Carpenter, 2011), Reid and Woolley (2006) highlighted issues associated with emotional dysregulation (Reid & Woolley, 2006). When reviewing different etiological concepts of CSB, Bancroft and Vukadinovic (2004) stated, "We regard the role of affect to be important in most, if not all, cases of out of control sexual behavior" (p. 231). They suggested 3 routes through which dysregulated, negative affect may contribute to CSB: sexual arousability and compulsive-like sexual activity that may reflect attempts to meet regulatory goals during negative emotional states; sexual stimulation that may be used as a distractor from stimuli or situations inducing negative mood; and, sexual arousal that may become a conditioned response to highly arousing negative moods. Recent, multivariable, integrative models focusing on the nature and etiology of CSB also cite the importance of emotional dysregulation (Grubbs, Perry, Wilt, & Reid, 2018; Walton, Cantor, Bhullar, & Lykins, 2017).

Collectively, the aforementioned research underscores the importance of associations between emotion-regulation or stress-proneness and CSB. A prominent role for emotional regulation has also been described for gambling disorder, a condition that was previously classified as an impulse control disorder and now as a behavioral addiction. Specifically, emotional regulation operationalized as negative-reinforcement motivations has been described as a main pathway for developing and maintain gambling disorder (Błaszczynski & Nower, 2002). It is plausible that negative affective states may constitute both precipitating and perpetuating risk factors for CSB. Interestingly, DSM-5 criteria for gambling disorder include an emotional-regulation-related criterion whereas the ICD-11 criteria do not. As such, the above-noted differences may reflect consistent differences in ways that the governing bodies, the World Health Organization and American Psychiatric Association, conceptualize central criteria of these disorders. Models of tension reduction or self-medication hypotheses posit that potentially addictive behaviors that create a mood-altering experience may function via negative-reinforcement mechanisms to modulate negative affective states or reduce stress (Gola & Potenza, 2016; Kasten, 1999; Khantzian, 1987; Wordecha et al., 2018), and these should be considered in presenting features of patients seeking treatment for CSBD. While this process may be facilitated by inclusion of these features within the criteria, clinicians have long assessed clinically relevant aspects of a disorder even when they are not included as central criteria (e.g., gambling urges in gambling disorder).

At present, it is not entirely clear why emotion regulation-related or stress-proneness criteria were excluded from the ICD-11 criteria for CSBD. We encourage and advocate for an open discussion on this subject as a catalyst for how the core

elements of CSBD are conceptualized and how efforts related to CSBD are approached in research and clinical settings. When defining the criteria for CSBD, it may be important to consider how core symptoms may be distinguished from underlying psychological processes, as has been recently described for gaming disorder and other addictive behaviors (Brand, Rumpf, King, Potenza, & Wegmann, 2020).

DIMINISHED PLEASURE

Additional discussion regarding similarities and differences between HD and CSBD criteria is warranted. Compared to HD, CSBD criteria differ in that they explicitly include continuation of sexual behavior when deriving little or no pleasure (WHO, 2020). This seems to reflect proposed "compulsive" underpinnings of the disorder suggesting sexual behavior among diagnosed individuals may be driven by non-pleasure-related factors; such factors may include sex as a habitual or conditioned behavior or attempts to reduce obsessive thoughts and/or associated negative affect (Barth & Kinder, 1987; Stein, 2008; Walton et al., 2017). Diminished pleasure derived from sexual behavior may also reflect tolerance related to repetitive and excessive exposure to sexual stimuli, which are included in addiction models of CSBD (Kraus, Voon, & Potenza, 2016) and supported by neuroscientific findings (Gola & Draps, 2018). An important role for tolerance relating to problematic pornography use is also suggested in community and subclinical samples (Chen et al., 2021). Further consideration of such phenomena as they relate to CSBD criteria may help differentiate between individuals with CSBD symptoms and those who engage with high frequency in sexual acts because of high sexual desires or drives (Carvalho, Štulhofer, Vieira, & Jurin, 2015), which was a prior point of scientific criticism of HD and CSBD (Prause, 2017).

CONSIDERING INCLUSIONARY CRITERIA

Furthermore, precisely how to consider each criterion for CSBD in making a diagnosis is not clearly described. Currently, there is a description of symptoms that may relate to a diagnosis, and less precise guidance regarding which and how many criteria are necessary versus optional for making a diagnosis (WHO, 2020). A diagnosis of HD required meeting criterion B and 3 out of 5 A-type criteria (see Table 1). Currently, such corresponding information is not presented for CSBD. This topic warrants additional examination in future research and clinical endeavors and further specification in the ICD-11.

MORAL INCONGRUENCE

The current description of CSBD also includes a statement that a diagnosis of CSBD should not be made if distress is related entirely to moral disapproval or judgments. This



statement reflects recent investigations into possible influences of religious and moral beliefs on seeking treatment for CSB (Grubbs et al., 2018; Grubbs, Kraus, Perry, Lewczuk, & Gola, 2020; Lewczuk, Szmyd, Skorko, & Gola, 2017; Lewczuk, Glica, Nowakowska, Gola, & Grubbs, 2020), data that were unavailable when HD was proposed for DSM-5. However, feelings of moral incongruence should not arbitrarily disqualify an individual from receiving a diagnosis of CSBD. For example, viewing of sexually explicit material that is not in alignment with one's moral beliefs (for example, pornography that includes violence towards and objectification of women (Bridges et al., 2010), racism (Fritz, Malic, Paul, & Zhou, 2020), themes of rape and incest (Bóthe et al., 2021; Rothman, Kaczmarzsky, Burke, Jansen, & Baughman, 2015) may be reported as morally incongruent, and objectively excessive viewing of such material may also result in impairment in multiple domains (e.g., legal, occupational, personal and familial). Also, one may feel moral incongruence about other behaviors (e.g., gambling in gambling disorder or substance use in substance use disorders), yet moral incongruence is not considered in the criteria for conditions related to these behaviors, even though it may warrant consideration during treatment (Lewczuk, Nowakowska, Lewandowska, Potenza, & Gola, 2020). There may also be important cross-cultural differences relating to religiosity that may impact perceived moral incongruence (Lewczuk et al., 2020). Furthermore, researchers have raised questions about whether models dichotomizing CSB involving the presence or absence of moral incongruence are as distinct as proposed (Brand, Antons, Wegmann, & Potenza, 2019). Thus, although moral incongruence may have clinical relevance in what motivates individuals to seek treatment for CSB (Kraus & Sweeney, 2019), its role in the etiology of and definition of CSBD warrants additional understanding.

SUBSTANCE USE AND BIPOLAR SYMPTOMATOLOGY

The criteria for CSBD do not explicitly consider other factors that may be relevant to diagnosis including substance use (Kafka, 2010; Reid & Meyer, 2016). How specific co-occurring behaviors (e.g., CSB limited to times of cocaine use in cocaine-use disorder or dopamine replacement therapies in Parkinson's disease) relate to CSBD warrants additional consideration. Similarly, CSB limited to manic episodes should be considered, as is currently the case for mania-related gambling with respect to gambling disorder.

CLASSIFICATION

The classification of CSBD as an impulse control disorder also warrants consideration. HD was considered by the DSM-5 Sexual and Gender Identity Disorders Workgroup (Kafka, 2014), and data suggest similarities between CSBD and addictive disorders (Gola & Draps, 2018; Kraus, Martino, & Potenza, 2016; Stark, Klucken, Potenza, Brand, &

Strahler, 2018). Additional research may help refine the most appropriate classification of CSBD as happened with gambling disorder, reclassified from the category of impulse control disorders to non-substance or behavioral addictions in DSM-5 and ICD-11. In line with this notion, some research has found impulsivity as an associated feature in less than half of patients seeking help for CSB (Reid, Cyders, Moghaddam, & Fong, 2014) and that impulsivity may not contribute as strongly to problematic pornography use as some have proposed (Bóthe et al., 2019).

TYPES OF SEXUAL BEHAVIORS

Behavioral symptoms similar to those falling under the scope of CSBD have been also studied within a narrower framework of problematic pornography use (de Alarcón, de la Iglesia, Casado, & Montejo, 2019). Given problematic pornography viewing and compulsive masturbation are often prominent behavioral manifestations of CSBD (Gola, Kowalewska et al., 2018; Reid et al., 2011), one may posit that problematic pornography use should be considered a subtype of CSBD, although alternate considerations have been described (Brand et al., 2022). The proposed criteria for HD (Kafka, 2010) included seven behavioral specifiers (i.e., Masturbation, Pornography, Sexual Behavior with Consenting Adults, Cybersex, Telephone Sex, Strip Clubs, Other) which were intended to help differentiate between various presentations of the disorder. In the ICD-11, no subtypes of CSBD are currently defined, which may be a task for future research. Data support possible heterogeneous mechanisms and presentations of problematic sexual behaviors (Carvalho et al., 2015; Knight & Graham, 2017; Kingston, 2018a, 2018b), which may be investigated further with the criteria for CSBD in mind. With respect to scientific research, recognition of CSBD in the ICD-11 may facilitate the bringing together of related but sometimes disparate lines of research (problematic pornography use, pornography and sex addiction, problematic cybersex, hypersexuality), which could generate greater scientific clarity and expedite research and clinical advances.

ASSESSMENT

To progress towards a goal of more unified research, measures assessing CSBD symptoms that adequately reflect each of the CSBD criteria and its relative significance should be developed and validated. This task, while crucial, had proven to be difficult in the past for HD, as screening measures for HD were criticized for over-diagnosing general population participants, at least in some samples (e.g., Walton et al., 2017). Initial efforts have included the development of a 19-item scale that has been validated across three languages (Bóthe et al., 2020). Additional research is needed to examine its validity and reliability in other jurisdictions that may have different cultural considerations about sex (among other differences) and to investigate its research and clinical utilities.



CLINICAL IMPLICATIONS

Regardless of the need for additional clarity as discussed in this paper, including CSBD in the ICD-11 should be helpful to treatment-seeking individuals and healthcare providers. Approximately one in seven men viewing pornography reported interest in seeking treatment for their pornography consumption, and those interested in treatment were considerably more likely to meet a clinical threshold for hypersexuality (Kraus, Martino, & Potenza, 2016). As such, the inclusion of CSBD in the ICD-11 is a welcomed addition that should have a significant clinical impact. Researchers should be able to build upon the foundation of the CSBD criteria to provide additional insights and perspectives about the disorder and its associated features and help promote clinical advances.

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