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COMMENTARY



Assessment of compulsive sexual behavior disorder among lesbian, gay, bisexual, transgender, and queer clients

Commentary to the debate: “Behavioral addictions in the ICD-11”

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ABSTRACT

Numerous debates surround the recent inclusion of compulsive sexual behavior disorder (CSBD) in the International Classification of Diseases (11th ed.), such as the appropriate classification of this construct and what symptom criteria best capture this syndrome. Although controversy surrounding CSBD abounds, there is general agreement that researchers should examine this syndrome in diverse groups, such as lesbian, gay, bisexual, and transgender populations. However, there have been few investigations into how diverse sociocultural contexts may influence the assessment and treatment of CSBD. Therefore, we propose several differential diagnosis considerations when working with sexual and gender diverse clients to avoid CSBD misdiagnosis.

KEYWORDS

compulsive sexual behavior disorder, differential diagnosis, LGBTQ+ clients

INTRODUCTION

Individuals with symptoms of Compulsive Sexual Behavior Disorder (CSBD) experience distress or impairment in functioning due to failure to control sexual thoughts and impulses resulting in repetitive sexual behavior (World Health Organization [WHO], 2018). The inclusion of CSBD in the *International Classification of Diseases* (11th ed.; ICD-11) generated heated debate (Kraus et al., 2018; WHO, 2018) among researchers and clinicians. Presently, experts disagree on the classification of CSBD as an addiction (Sassover & Weinstein, 2022), what symptom criteria should comprise the diagnostic framework of CSBD (Gola et al., 2022), and whether specific manifestations of CSBD (e.g., compulsive pornography use) constitute a separate disorder (Brand et al., 2022). Although disagreements exist, a point of consensus among researchers is that the assessment of CSBD in diverse populations merits additional attention (Griffin, Way, & Kraus, 2021). Therefore, in addition to addressing common controversies surrounding CSBD, we provide differential diagnosis recommendations for sexual and gender diverse clients seeking help for this syndrome.

CSBD CONTROVERSIES

Currently, classifying CSBD as an impulsive, compulsive, or addictive disorder remains controversial. For instance, in a review of papers on CSBD classification, Sassover and

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Weinstein (2022) assert there is insufficient data to conceptualize CSBD as an addictive disorder. Although this perspective is well intentioned, we contend that classification debates cannot progress without also testing theoretical models of CSBD. As noted elsewhere (Gola & Potenza, 2018; Prause, 2017), the most helpful course of action would be to test different conceptualizations of CSBD rather than debate its optimal classification.

Other debates concern the utility of specifiers for CSBD. Gola et al. (2022) aptly noted the possibility of including behavioral specifiers in the diagnosis of CSBD, such as a pornography subtype. Another possibility is to determine whether pornography use is better conceptualized as a separate disorder (Brand et al., 2022) rather than a CSBD specifier. However, the answer to these debates may be of little consequence to diverse populations if differential diagnoses for CSBD are not clarified first. Indeed, the unique sociocultural contexts of diverse populations may complicate the accurate assessment of CSBD and result in misdiagnosis. Moreover, inaccurate diagnoses may compromise the quality of health care diverse clients receive. To address this concern, we describe the sociocultural context of LGBTQ+ clients to inform culturally competent diagnosis of CSBD for these populations.

A PRIMER ON MEYER'S MINORITY STRESS MODEL

Meyer's (2003) Minority Stress Model and its applications to transgender persons (Bockting, Miner, Swinburne-Romine, Hamilton, & Coleman, 2013) asserts that LGBTQ+ populations endure stressors related to their stigmatized sexual or gender identity. The model describes two broad types of minority stressors: distal and proximal. *Distal stressors* are external events of prejudice, such as familial rejection or discrimination. *Proximal stressors* occur as internal processes in response to external events of prejudice, such as internalized homonegativity or anticipated discrimination (Meyer, 2003). Both proximal and distal stressors compromise the mental and physical health of LGBTQ+ people.

Based on the premises of minority stress theory, LGBTQ+ individuals may be disproportionately affected by CSBD due to proximal and distal stressors. This proposition has received support in a study from Pachankis et al. (2015) documenting associations between experiences of discrimination (i.e., distal stressor) and sexual compulsivity via internalized homonegativity (i.e., proximal stressor) and emotion dysregulation among men who have sex with men (MSM). Several researchers have also found that compulsive sexual behavior (CSB) may be more prevalent among MSM (Bóthe et al., 2018; Paz, Griffiths, Demetrovics, & Szabó, 2019), suggesting that this population may be disproportionately affected by this syndrome. While these findings have yet to be fully considered in other sexual and gender diverse populations (Griffin et al., 2021), minority stressors may confer greater risk for CSBD among LGBTQ+ clients broadly, and therefore, culturally competent research and

clinical consideration is critical. We assert three factors jeopardizing the accurate assessment of this syndrome in LGBTQ+ clients: conflation of minority stressors and CSBD symptoms, clinician bias, and methodological flaws in CSBD measurement.

MINORITY STRESS AND CSBD DIFFERENTIAL DIAGNOSIS

Thus far, differential diagnosis considerations for CSBD have focused on the moral incongruence (MI) rule-out, which states that distress entirely related to moral disapproval of sexual urges and behaviors should not be diagnosed as CSBD. This rule-out is based on research indicating that moral disapproval of one's sexual behavior may lead clients to *self-perceive* symptoms of CSBD (Grubbs, Perry, Wilt, & Reid, 2019). However, MI has been almost exclusively examined in Christian, heterosexual, cisgender, and White American samples of pornography users, limiting the generalizability of this rule-out criterion (Jennings, Lyng, Gleason, Finotelli, & Coleman, 2022). Furthermore, we contend that minority stress related distress and impairment (MSRDI) experienced by LGBTQ+ clients may be mistaken for CSBD, leading to misdiagnosis, and one possible remedy for this issue could be further consideration of how proximal and distal minority stress complicate assessment of CSBD in these populations.

Proximal and distal stressors

Proximal minority stressors should be ruled out in the diagnosis of CSBD. The MI rule-out may represent a highly relevant proximal stressor for LGBTQ+ clients and is likely a form of internalized homo- or transnegativity, given that LGBTQ+ clients often internalize stigma society directs toward their diverse identities (Bockting et al., 2013; Meyer, 2003), and thus morally disapprove of their sexual impulses, thoughts, or behaviors. For clients with diverse sexual attractions, MI may stem from disapproval of the sexual activity itself (e.g., watching pornography), aspects of the sexual activity related to diverse sexuality (e.g., watching gay pornography), or disapproval of both. In LGBTQ+ populations, clinicians should determine whether MI-related distress is attributed to internalized stigma, as such a presentation requires consideration related to the sociocultural context of LGBTQ+ clients. Table 1 presents other examples of proximal stressors that may be misinterpreted as CSBD symptoms.

Distal stressors should also be ruled out in the diagnosis of CSBD. As an example, one CSBD symptom involves continually engaging in repetitive sexual behavior despite adverse consequences (e.g., occupational consequences, relationship disruption). However, LGBTQ+ clients may experience relationship disruption or occupational consequences due to family or colleagues holding prejudicial attitudes toward their diverse sexuality or gender. To avoid misdiagnosis of CSBD among LGBTQ+ clients, clinicians must accurately identify whether adverse consequences associated with sexual behavior arise from prejudice (i.e., distal stressor)



Table 1. Examples of minority stressors complicating the diagnosis of CSBD

CSBD symptom criteria (ICD-11)	Minority Stress Model	
	Proximal Stressors	Distal Stressors
1A. Engaging in repetitive sexual activities has become a central focus of the person's life to the point of neglecting health and personal care or other interests, activities, and responsibilities.	LGBTQ+ clients may experience internalized stigma that leads them to view their sexual thoughts or behavior as repetitive to the point of neglecting other aspects of life.	Exposure to interpersonal victimization or familial rejection may predispose LGBTQ+ clients to view their sexuality as harmful toward aspects of their life.
1B. The person has made numerous unsuccessful efforts to control or significantly reduce repetitive sexual behavior.	LGBTQ+ client efforts to reduce diverse sexual behavior or urges may reflect internalized stigma, rather than CSBD.	The LGBTQ+ client's family encourages them to date partners of the opposite gender. The client attempts to appease their family by attending conversion therapy to reduce their attractions to partners of the same gender.
1C. The person continues to engage in repetitive sexual behavior despite adverse consequences (e.g., repeated relationship disruption, occupational consequences, negative impact on health).	An LGBTQ+ client may hide their sexual orientation due to a fear of rejection from their therapist. Ruling out MSRDI without this information is difficult.	LGBTQ+ clients may be fired from their workplace due to their sexual or gender identity. Occupational consequences are due to MSRDI, not CSBD.
1D. The person continues to engage in repetitive sexual behavior even when the individual derives little or no satisfaction from it.	LGBTQ+ clients may report less sexual satisfaction when there is intense internalized disapproval of their sexual behavior.	External events of prejudice contribute to the development of internalized stigma.
2. The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behavior is manifested over an extended period (e.g., 6 months or more) (Must be met)	Distress or impairment arising from proximal stressors may last for 6 months and up to a lifetime.	Distress or impairment arising from distal stressors may last for 6 months and up to a lifetime.
3. The pattern of repetitive sexual behavior causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning (Must be met).	Distress may be related to internalization of stigma and moral/religious disapproval of their behavior. Rumination on experiences of discrimination may also be a source of MSRDI.	Impairment in personal, family, social, educational, occupational, or other areas of functioning may be due to discriminatory attitudes rather than CSBD.
Note for rule out. Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviors is not enough to meet this requirement.	A construct that may represent a specific form of internalized homo- or transnegativity for LGBTQ+ clients.	This distress may be caused by experiences of discrimination or by institutional homonegativity.

Note. Abbreviations are minority stress related distress or impairment (MSRDI) and lesbian, gay, bisexual, transgender, and queer (LGBTQ+).

or dysregulated sexual behavior. Table 1 presents other examples of distal stressors that may be misinterpreted as CSBD symptoms.

Addressing minority stress and CSBD in LGBTQ+ clients

Given concerns with minority stress related distress and impairment (MSRDI), clinicians may encounter three broad presentations in the diagnosis of CSBD among LGBTQ+ clients:

1. The LGBTQ+ client meets CSBD criteria and evinces no MSRDI that would invalidate a diagnosis.

2. MSRDI is the primary source of distress for the LGBTQ+ client and they do not meet CSBD symptom criteria.

3. The LGBTQ+ client meets CSBD symptom criteria and is experiencing MSRDI.

To accurately diagnose CSBD among LGBTQ+ clients, clinicians should distinguish among these three clinical presentations (see Fig. 1). Notably, treatment will require specialized consideration of an LGBTQ+ client's needs, as MSRDI can also contribute to the development of CSBD symptomology (Pachankis et al., 2015). In the present paper, we illustrate how MSRDI may be confused for CSBD in the diagnostic process, but it bears mention that MSRDI may also erode protective mechanisms and contribute to CSBD



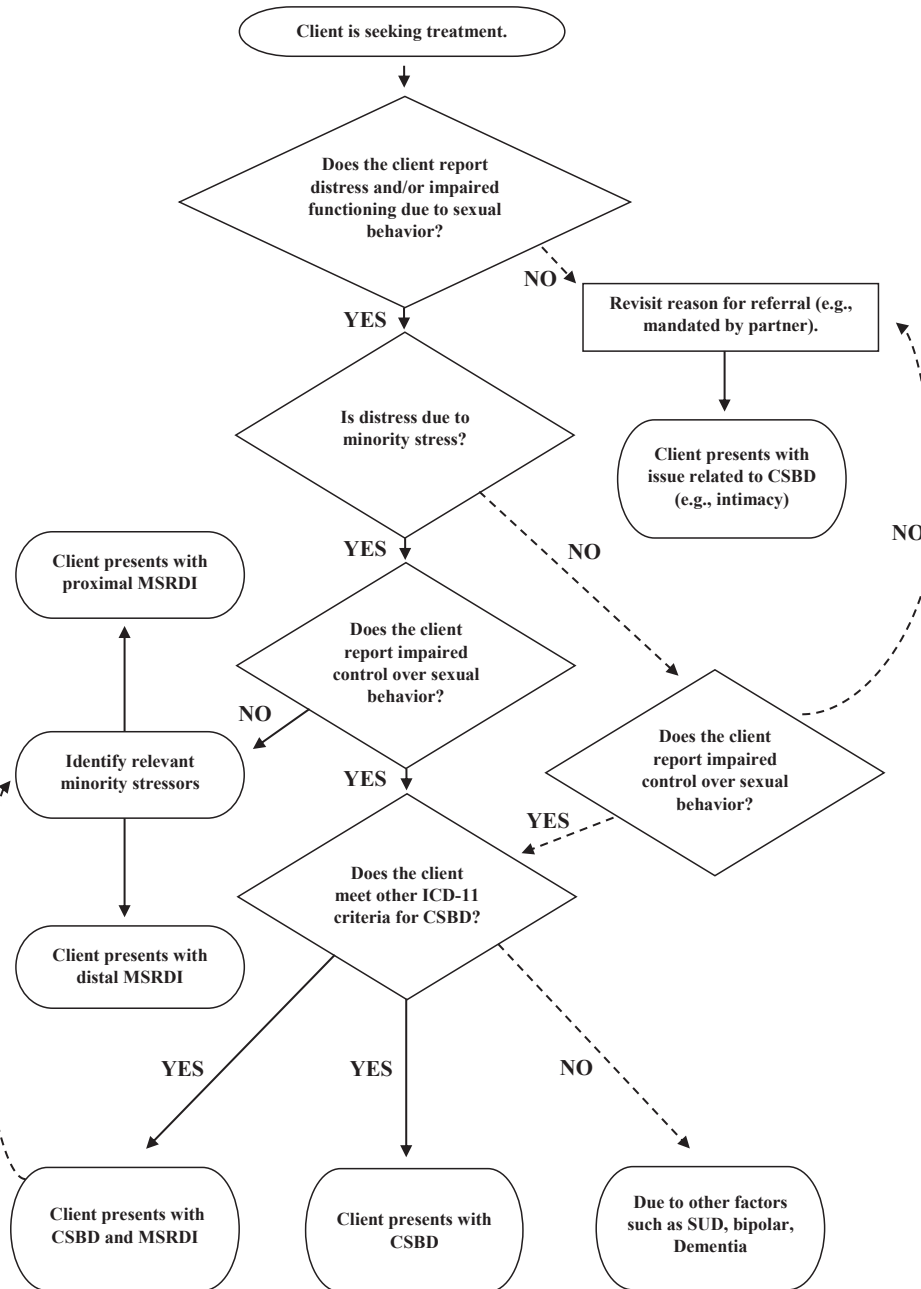


Fig. 1. CSBD differential diagnosis algorithm for LGBTQ+ clients

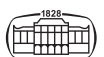
etiology, requiring the development of adapted therapeutic interventions targeting the specific needs of LGBTQ+ clients with CSBD (Pachankis, Soulliard, Morris, & van Dyk, 2022).

In addition to considering LGBTQ+ identity and minority stress in the broader case conceptualization, addressing issues of MI (i.e., proximal stressor) must radically differ for LGBTQ+ clients. One component of a current treatment for MI includes helping the client live in accord with their sexually restrictive values (Grubbs et al., 2019). For instance, a client struggling with MI related distress involving pornography may receive therapy that helps them reduce their use. Using this approach with LGBTQ+ clients is reminiscent of conversion therapy, or therapy that aims to change a client’s sexual or gender diversity. Conversion

therapy is widely considered to be pathologizing, discriminatory, and harmful to LGBTQ+ clients (Pachankis & Goldfried, 2004), and has been banned in many countries and US states (Movement Advancement Project, 2021). Thus, it would be more appropriate to utilize affirmative treatment approaches to validate the client’s sexual attractions, behaviors, and identity (Drescher, 2015; Pachankis & Goldfried, 2004).

CONCERNS WITH CLINICIAN BIAS

Clinician bias in the diagnosis of CSBD among LGBTQ+ clients remains a concerning possibility. Clinicians must



distinguish between symptoms of CSBD and various distal and proximal minority stressors. Further complicating this clinical situation is the possibility of heteronormative bias among clinicians, leading them to perceive normative LGBTQ+ experiences as CSBD symptoms. Although little research has examined this proposition, other studies have documented clinician bias in diagnosing borderline personality disorder in LGBTQ+ clients (Eubanks-Carter, C., 2006; Rodriguez-Seijas, Morgan, Zimmerman, 2020). Studies have also identified connections between social anxiety, characterized by a fear of being negatively evaluated by others, and condomless sex among gay and bisexual men (Hart & Heimberg, 2005; Wang & Pachankis, 2016). Clinicians exhibiting bias could interpret condomless sex as a symptom of CSBD rather than a client's concern with experiencing rejection from sexual partners. Lastly, some clinicians may underdiagnose CSBD in sexually diverse clients if they tend to view symptoms of CSBD as normative and biologically based in these populations (Klein, Briken, Schröder, & Fuss, 2019). Although little consideration has been given to clinician bias in the diagnosis of CSBD among LGBTQ+ clients, we suspect that such bias may contribute to inaccurate diagnosis.

CONCERNS WITH MEASUREMENT

Similar to CSBD symptom criteria, measurement of CSB in research contexts has rarely considered the possibility of conflating minority stressors with dysregulated sexual behavior. For instance, one of the oldest measures of sexual addiction (a CSBD related construct), the Sexual Addiction Screening Test (SAST; Carnes, 1989), considers secret sexual outlets and sexual activities creating problems with families as possible indicators of sexual addiction. However, LGBTQ+ individuals may hide their sexual activity because of a rational fear of rejection or discrimination from family, friends, colleagues, and their religious community (Moe, Finnerty, Sparkman, & Yates, 2015). Contemporary measures of CSB related constructs commonly used among gay and bisexual men, such as the Sexual Compulsivity Scale (Hook, Hook, Davis, Worthington, & Penberthy, 2010), also do not account for possible minority stress confounds. Therefore, it is difficult to know whether past studies reporting on CSB related constructs among LGBTQ+ populations are capturing dysregulated sexual behavior, MSRDI, or both.

To address this concern, researchers should measure minority stressors that might complicate the accurate diagnosis or measurement of CSBD among LGBTQ+ groups. A similar issue is that measurement invariance for CSBD criteria and common measures of CSB have not been well established for LGBTQ+ people, though some initial research has explored this area (Bóthe et al., 2018). Future research is needed to develop these neglected areas and promote precision in the measurement of CSBD in LGBTQ+ populations.

FUTURE RESEARCH RECOMMENDATIONS

The sociocultural context of LGBTQ+ clients merit further consideration in CSBD research and clinical studies. Most notably, understanding of CSBD research thus far has been primarily limited to the GB in LGBTQ+. Future research should examine this syndrome in other sexual and gender diverse populations. In particular, transgender and queer populations have seldom received attention in the CSB research literature. As discussed elsewhere (Griffin et al., 2021), intersectionality considerations surrounding sexual orientation, gender, race/ethnicity, and other demographic variables remain understudied and merit further investigation. Lastly, in addition to addressing concerns with clinician bias and the conflation of MSRDI and CSBD, future consideration should be given to adapting CSBD interventions to be LGBTQ+ affirming.

CONCLUSION

Both clinicians and researchers should carefully consider the sociocultural context of LGBTQ+ clients in the assessment and treatment of CSBD. The risk of misdiagnosis of CSBD in these populations may be particularly high for LGBTQ+ clients, given the confounding influences of multiple minority stress variables, clinician bias, and measurement concerns. Treatments should prioritize LGBTQ+ affirming care to avoid pathologizing sexual and gender diverse clients. These practices would aid in the accurate diagnosis and treatment of CSBD in LGBTQ+ clients and promote culturally competent care for these populations.

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