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COMMENTARY



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Where to put Compulsive Sexual Behavior Disorder (CSBD)? Phenomenology matters

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

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ABSTRACT

In this commentary paper, it is discussed if Compulsive Sexual Behavior Disorder (CSBD) is best categorized as an Impulse Control Disorder, an Obsessive-Compulsive Disorder or in light of the overlap of characteristics with both Gaming and Gambling Disorder as an addictive behavior. The overlapping features are: loss of control over the respective excessive behavior, giving increasing priority to the excessive behavior under investigation and upholding such a behavior despite negative consequences. Besides empirical evidence regarding underlying mechanisms, phenomenology also plays an important role to correctly classify CSBD. The phenomenological aspects of CSBD clearly speak in favor of classifying CSBD under the umbrella of addictive behaviors.

KEYWORDS

Compulsive Sexual Behavior Disorder, Gambling Disorder, Gaming Disorder, Pathological Gambling, impulsivity, Impulse Control Disorder, addictive behavior

INTRODUCTION

The investigation of behavioral addictions represents a timely and important research topic and got rising attention, in particular with the inclusion of Gaming Disorder as an addictive behavior in the recent International Classification of Diseases - 11th version (ICD-11) which has been appreciated by scholars and clinicians (Billieux, Stein, Castro-Calvo, Higushi, & King, 2021; Pontes et al., 2019; Rumpf et al., 2018; Saunders et al., 2017). Beyond Gaming Disorder, other behavioral conditions are currently discussed to perhaps be included as a behavioral addiction in the next revision of the International Classification of Diseases (Montag, Wegmann, Sariyska, Demetrovics, & Brand, 2021). Among these are behaviors related to excessive buying or excessive social media use (Brand, Rumpf, Demetrovics, et al., 2022). In this realm, also another disorder has been the focus of debate, namely Compulsive Sexual Behavior Disorder (CSBD). CSBD is officially recognized in the recent ICD-11, but interestingly not as an addictive disorder, but as an Impulse Control Disorder.¹ Not all researchers agree upon the correctness of this classification. For instance, Gola et al. (2022) made the observation that “data suggest similarities between CSBD and addiction” and they are of the opinion that with additional empirical evidence CSBD might be reclassified as an addictive behavior (p. 4). Such a reclassification would not happen for the first time. For

¹<https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1630268048>.

instance, whereas Pathological Gambling was categorized as an Impulse Disorder in ICD-10 (Habit and Impulse Disorders), it now is categorized as Gambling Disorder among the category of Disorders due to Addictive Behaviours. According to ICD-10, habit and impulse disorders “are characterized by repeated acts that have no clear rational motivation, cannot be controlled, and generally harm the patient’s own interests and those of other people.” Moreover, the afflicted patients report “that the behaviour is associated with impulses to action.”² Although loss of control and significant impairment due to excessive gambling still play an important role in the diagnosis of Gambling Disorder in ICD-11, the “impulses to action” are not included as a clinical description anymore.

Is it likely that CSBD will also go the way from belonging to the category of an Impulse Control Disorder to a Disorder Due to Addictive Behaviours in the near future? [Sassover and Weinstein \(2022\)](#) come to the conclusion that an answer to this question cannot be provided at the moment, because current evidence regarding this question is “anecdotal” and “insufficient” (p. 1). Although we do not agree with this view, the authors have to be commended for critically summarizing the evidence and for the reminder to be cautious in making premature assignments. But what kind of evidence would be needed to be observed to speak of an addictive behavior (and not of a compulsive or impulsive behavior)? In short, [Brand, Rumpf, Demetrovics et al. \(2022\)](#) mention three areas to be scrutinized. First, the observed addictive behavior needs to be clinically relevant going along with significant impairments in the life of the afflicted person. Second, the investigated excessive behavior can be best explained by an addiction framework and third empirical evidence from psychology, psychiatry and the neurosciences should back up such a theoretical fit.

COMPARISON OF THE DIAGNOSTIC GUIDELINES OF CSBD WITH GAMING AND GAMBLING DISORDER

[Sassover and Weinstein \(2022\)](#) summarize the existing evidence by using the components model of [Griffiths \(2005\)](#) and come to the conclusion that most studies have not used all 6 components resulting in a fragmented picture that provides not sufficient evidence to categorize CSBD as a behavioral addiction. Although the components model has been very helpful in the early days of research on behavioral addictions, it has been criticized because it was used in many studies as an underlying concept to introduce or confirm moot behavioral addictions that lack clinical evidence and pathologize every day behavior (e.g. [Starcevic, Billieux, & Schimmenti, 2018](#)). Moreover, it has been argued that the components model mixes up core and peripheral criteria and does not sufficiently include functional impairment as a

prerequisite to constitute a behavioral addiction ([Billieux, Flayelle, Rumpf, & Stein, 2019](#)). In addition, more current alternative approaches such as frameworks basing on the criteria of Internet Gaming Disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, [American Psychiatric Association, 2013](#)) are available. However, from our view the most appropriate way to shed light on the question whether CSBD constitutes a behavioral addiction would have been to take the definition of Gambling and Gaming disorder in the ICD-11 as a basis for judgement. By doing so, it becomes apparent that the clinical description of both disorders show strong similarities as can be seen in [Table 1](#), where we contrast diagnostic guidelines of CSBD with those of Gaming Disorder and Gambling Disorder. This observation has also been made by [Brand, Rumpf, Demetrovics et al. \(2022\)](#) who state that “diagnostic guidelines share several features with those for compulsive sexual behavior disorder” (p. 4). In all three conditions, the characteristics of loss of control, giving increasing priority to the excessive behavior under investigation and continuing the problem behavior despite negative consequences are present. Given this strong overlap of diagnostic guidelines,

Table 1. Contrasting the symptoms of Compulsive Sexual Behavior Disorder (an impulse control disorder) with symptoms of Gaming Disorder/Gambling Disorder (addictive behaviors) based on the classifications in ICD-11

Compulsive Sexual Behavior Disorder (6C72)	Gaming Disorder (6C50) and Gambling Disorder(6C51)
A persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behavior	Impaired control over gaming/gambling (e.g., onset, frequency, intensity, duration, termination, context)
Numerous unsuccessful efforts to significantly reduce repetitive sexual behavior	
Repetitive sexual activities becoming a central focus of the person’s life to the point of neglecting health and personal care or other interests, activities and responsibilities	Increasing priority given to gaming/gambling to the extent that gaming takes precedence over other life interests and daily activities;
Continued repetitive sexual behavior despite adverse consequences or deriving little or no satisfaction from it	Continuation or escalation of gaming/gambling despite the occurrence of negative consequences
Marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning	Significant distress or significant impairments in personal, family, social, educational, occupational, or other important areas of functioning

Please note that the here presented symptoms have been taken from the ICD-11 website (and were slightly modified and/or shortened). <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1630268048>; <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1448597234>.

²<https://icd.who.int/browse10/2019/en#/F63.0>.



one might question that CSBD belongs to the group of Impulse Control Disorder and might better qualify as addictive behavior. Although the diagnostic guidelines of CSBD and behavioral addictions such as Gambling or Gaming Disorder are clearly convergent, we agree with [Sassover and Weinstein \(2022\)](#) that the line between impulsive and addictive behaviors cannot be drawn easily, because impulse control is not only a central feature of Impulse Control Disorders, but plays as well an important role in addictive behaviors as seen for example in substance use disorders ([Moeller & Dougherty, 2002](#); [Perry & Carroll, 2008](#)), for instance, when participants are confronted with a drug cue ([Jones, Vadhani, Luba, & Comer, 2016](#)). Moreover, CSBD might share commonalities with compulsive behavior.

HOW DO PHENOMENOLOGICAL CHARACTERISTICS OF DISORDERS IN THE CATEGORIES OF OBSESSIVE-COMPULSIVE DISORDERS AND IMPULSE CONTROL DISORDERS RELATE TO CSBD?

However, the phenomenology of conditions grouped in the ICD-11 as Obsessive-Compulsive Disorders, Impulse Control Disorders and Disorders Due to Addictive Behaviours draw a clear picture. Although [Sassover and Weinstein \(2022\)](#) argue that findings on compulsive components of CSBD should be given more attention, CSBD has very little similarities to the symptomatology of other disorders in this category such as Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, Olfactory Reference Disorder, Hypochondriasis, and Body-Focused Repetitive Behavior Disorder. In all of these conditions, the avoidance of negative states such as tension or fears is in the focus and pleasurable experiences or positive reward is typically missing in most of the conditions; exceptions can be found partly in Body-Focused Repetitive Behavior Disorder in which behaviors such as hair-pulling or skin-picking may lead to gratification, pleasure or relief. Given the semiologic discrepancy described above, CSBD seems not to fit into the area of obsessive-compulsive disorders. The current taxonomy finds CSBD in company with other Impulse Control Disorders such as Pyromania, Kleptomania, and Intermittent Explosive Disorder. Differences between non-pathological and pathological states in these disorders are more of qualitative than of quantitative nature. All substance-related or behavioral addictions start with a behavior which is rather common in society or within the peer group such as alcohol drinking, smoking, gambling or gaming. Based on mechanisms described in models of addictive behaviors (e.g. [Brand et al., 2016, 2019](#)) such behavior shows increases in frequency and quantity to an extent that it interferes with functionality. Contrary, in Kleptomania, Pyromania, and Intermittent Explosive Disorder, predominantly a qualitative change in behavior occurs. Individuals suffering from these disorders start to show “novel” (abnormal) behavior and

repeat it. This might be seen in a similar way in Body-Focused Repetitive Behavior Disorder. In the course of these conditions, frequency of behavior might increase over specific periods, can be intermittent or chronic. However, the mostly slow and continuous increase of unproblematic behavior as seen in addictions is not observable. In the light of these phenomenological considerations, CSBD does not really match with the category of Impulse Control Disorder.

CONCLUSIONS

It has to be kept in mind that these differences in phenomenology need to be backed up by studies comparing psychological mechanisms such as cue-reactivity, craving or attentional bias as well as neurobiological alterations directly contrasting CSBD with other (addictive and non-addictive) disorders. Given the evidence, that we see currently, as well as the similarities and discrepancies in phenomenology as well as the diagnostic guidelines in the ICD-11, we are convinced that CSBD appears more likely to be a Disorder due to Addictive Behaviors than an Obsessive-Compulsive Disorder or an Impulse Control Disorder.

Nevertheless, the paper of [Sassover and Weinstein \(2022\)](#) has made an important contribution by stimulating such discussions and outlining future research goals. We fully agree with the authors that it is necessary to use and interpret criteria of addiction homogeneously to move the field forward. At the same time, their recommendation to use the DSM-5 criteria for Gambling Disorder for this purpose is not supported by us. The Gambling Disorder criteria have been the basis of the description of Internet Gaming Disorder (IGD) as a condition for further study in the DSM-5. The IGD-approach has been criticized to include underlying processes ([Brand, Rumpf, King, Potenza, & Wegmann, 2020](#)) or peripheral criteria ([Billieux et al., 2019](#)) besides core criteria, both of which potentially may lead to over-pathologization. This is supported by empirical data (e.g. [Besser, Loerbroks, Bischof, Bischof, & Rumpf, 2019](#)) and expert appraisals in a Delphi-study ([Castro-Calvo et al., 2021](#)). Instead of using the DSM-5 criteria for Gambling Disorder, we strongly recommend to take advantage of the diagnostic guidelines for behavioral addictions lined out in the ICD-11.

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