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REVIEW ARTICLE

LGBQ-affirming clinical recommendations for compulsive sexual behavior disorder

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ABSTRACT

Background and aims: Since the inclusion of Compulsive Sexual Behavior Disorder (CSBD) in the *International Classification of Diseases* (11th ed.), there has been little effort placed into developing clinical recommendations for lesbian, gay, bisexual, and queer (LGBQ) clients with this condition. Thus, we develop preliminary clinical recommendations for mental health professionals working with LGBQ clients who may be struggling with CSBD. *Methods:* The present paper synthesizes the CSBD literature with advances in LGBQ-affirming care to develop assessment and treatment recommendations. These recommendations are discussed within the context of minority stress theory, which provides an empirically supported explanation for how anti-LGBQ stigma may contribute to the development of mental health conditions in LGBQ populations. *Results:* Assessment recommendations are designed to assist mental health professionals in distinguishing aspects of an LGBQ client's sociocultural context from CSBD symptomology, given recent concerns that these constructs may be wrongly conflated and result in misdiagnosis. The treatment recommendations consist of broadly applicable, evidence-based principles that can be leveraged by mental health professionals of various theoretical orientations to provide LGBQ-affirming treatment for CSBD. *Discussion and Conclusions:* The present article provides theoretically and empirically supported recommendations for mental health professionals who want to provide LGBQ-affirming care for CSBD. Given the preliminary nature of these recommendations, future research is needed to investigate their clinical applicability and efficacy.

KEYWORDS

compulsive sexual behavior, LGBQ-affirming care, sexual addiction, LGBQ mental health, minority stress

INTRODUCTION

The recent inclusion of Compulsive Sexual Behavior Disorder (CSBD) in the *International Classification of Diseases* (11th ed.; ICD-11) reflects the substantial progress in our scientific understanding of this condition (Reed et al., 2022; World Health Organization, 2022). However, there have been few efforts to translate this science into clinical recommendations for lesbian, gay, bisexual, and queer (LGBQ) clients (Jennings, Gleason, & Kraus, 2022). To address this issue, we integrate the CSBD literature with theoretical and empirical advances in LGBQ-affirming care. Based on this synthesis, we provide assessment and treatment considerations. Assessment recommendations center on concerns that CSBD symptoms may be conflated with the sociocultural context of LGBQ individuals, resulting in possible misdiagnosis (Jennings et al., 2022). Treatment recommendations involve adapting evidence-based interventions for CSBD to be LGBQ-affirming using an existing model from Pachankis, Soulliard et al. (2022). This article is intended

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to provide mental health professionals with concrete, actionable recommendations for delivering affirming care to LGBQ clients who may have CSBD.

While we primarily discuss clinical guidelines for assessing and treating CSBD among LGBQ clients, several recommendations in this paper warrant further investigation. Thus, we provide research recommendations for enhancing affirming clinical care of CSBD among LGBQ clients. These recommendations involve optimizing assessment and treatment practices for CSBD among LGBQ clients, understanding unique clinical characteristics and comorbidities of CSBD in these populations, and expanding investigation of CSBD to under-researched queer communities.

A BRIEF HISTORY OF CSBD AMONG LGBQ POPULATIONS

Academic attention toward excessive sexual behavior was jumpstarted by Patrick Carnes' writings on "sexual addiction" in the early 1980s (Carnes, 1983; Grubbs et al., 2020). Since then, mental health professionals have used several terms to refer to this condition, including out-of-control sexual behavior (Bancroft, 2008; Braun-Harvey & Vigorito, 2016), hypersexuality (Kafka, 2010; Stein, 2008), and compulsive sexual behavior (Coleman, 1991; Quadland, 1985). These variations in terminology reflect a history of controversy marked by myriad opposing etiological conceptualizations (Grubbs et al., 2020). While disagreements remain today, the ICD-11 classifies CSBD as an impulse control disorder (Reed et al., 2022). Broadly, CSBD refers to a pattern of failure to control sexual urges and impulses, resulting in repetitive sexual behavior that is impairing or distressing (World Health Organization, 2022). For clarity, we use "CSB" as an umbrella term for the various labels given to this construct (e.g., hypersexuality) and "CSBD" when referring to the ICD-11 diagnostic guidelines.

Central to the controversy surrounding CSB is the concern that diagnostic labels may be used to over-pathologize sexual minority populations (M. Klein, 2002; M. P. Levine & Troiden, 1988; S. B. Levine, 2010; Prause & Williams, 2020; Reay, Attwood, & Gooder, 2013). For example, some mental health professionals describe "homosexuality" as a symptom of "sexual addiction," a viewpoint that reflects bias against LGBQ identities and that has motivated sexual orientation change efforts (SOCE; Nicolosi, Byrd, & Potts, 2000). In a study of individuals who underwent SOCEs in the United Kingdom (Jowett, Brady, Goodman, Pillinger, & Bradley, 2021), many participants reported having experiences in 12-step programs where their same-gender attractions and behaviors were labelled as symptoms of addiction (Jowett et al., 2021). Similarly, other studies in the United States report that SOCEs often label same-gender attractions and behaviors as symptoms of addiction or other mental health problems (Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015; Fjelstrom, 2013; Schroeder & Shidlo, 2002). The preponderance of research indicates that SOCEs are harmful to LGBQ people (Green, Price-Feeney, Dorison, & Pick, 2020) and that LGBQ-affirming approaches produce better outcomes (American Psychological Association, 2021). Thus, the use of "sexual addiction" to facilitate SOCEs is an example of how CSB-related constructs have been used to harm LGBQ people. This, in turn, has likely led to skepticism in the scientific recognition of CSB, especially when applied to LGBQ clients.

As concerns regarding the over-pathologization of sexual behavior gained traction (M. P. Levine & Troiden, 1988), so too did literature suggesting that CSB may be a public health concern for LGBQ communities, particularly sexual minority men (Kalichman & Rompa, 1995). In the 1990s, Kalichman and Rompa (1995) developed and validated the Sexual Compulsivity Scale in a sample of sexual minority men. Research using this measure found that CSB was associated with condomless sex, greater number of sex partners, substance use before and during sex, and riskier sexual intentions among sexual minority men (Kalichman & Rompa, 1995; Rooney, Tulloch, & Blashill, 2018), which were particularly relevant concerns during the HIV pandemic. Adding to the relevance of CSB for LGBQ individuals, current studies indicate that LGBQ populations have similar or greater levels of CSB compared to their heterosexual counterparts, with men being at greater risk than women (Bőthe et al., 2018, 2023; Dickenson, Gleason, Coleman, & Miner, 2018; Gleason, Finotelli, Miner, Herbenick, & Coleman, 2021). Furthermore, CSB co-occurs with several psychosocial indicators of HIV risk among sexual minority men, such as depression, anxiety, and drug use, as shown by a meta-analysis of 36 studies (publication dates of studies ranged from 1997 to 2016; Rooney et al., 2018). While such research has not been extended to sexual minority women, this literature suggests that CSB may be a considerable public health concern for sexual minority men.

The tension between fears of over-pathologizing healthy sexuality and the need to address a significant public health issue has defined recent research and conceptualization of CSB. On both sides of the debate, there is concern for the well-being of LGBQ people, as there is evidence that LGBQ individuals have been over-pathologized by the misuse of CSB-related constructs (Jowett et al., 2021) *and* that CSB is a public health concern in these populations, particularly sexual minority men (Rooney et al., 2018). These perspectives are not mutually exclusive and to accept only one position may be a disservice to LGBQ clients. Therefore, we encourage mental health professionals to attend to both perspectives when providing care for LGBQ clients seeking treatment for sexual problems. The next section discusses how the sociocultural context of LGBQ clients may require special consideration in the provision of clinical care to LGBQ clients who may have CSBD.

MINORITY STRESS AND CSBD

Minority stress theory asserts that LGBQ individuals exist in sociocultural contexts characterized by stigma (e.g., negative

labeling, discrimination, and unequal power; Hatzenbuehler, Phelan, & Link, 2013) and that exposure to such stigma, as well as associated cognitive, affective, and behavioral stress responses, disproportionately compromises the mental health of LGBQ individuals (Brooks, 1981; Meyer, 2003). Within minority stress theory, external events of stigma and associated stress responses are categorized into two different forms of minority stress: distal and proximal. Distal stress refers to external events of stigma, such as anti-LGBQ laws (Hatzenbuehler, 2016; Hatzenbuehler, Pachankis, & Wolff, 2012) and familial rejection (Maiolatesi, Clark, & Pachankis, 2022; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Proximal stress occurs in response to external events of stigma (i.e., distal stress) and are internal stress processes, such as internalized homonegativity (Newcomb & Mustanski, 2010), rejection hypervigilance (Pachankis, Goldfried, & Ramrattan, 2008), identity concealment (Pachankis, Mahon, Jackson, Fetzner, & Bränström, 2020), and loneliness (McDanal, Schleider, Fox, & Eaton, 2023). Both distal and proximal stress are theorized to result in an increased vulnerability to developing mental health concerns among LGBQ individuals, such as depression, substance use, and suicidality (Bostwick, Boyd, Hughes, & McCabe, 2010; Rodriguez-Seijas, Eaton, & Pachankis, 2019).

Consideration has also been given to how minority stress may contribute to an increased vulnerability to developing CSB among LGBQ individuals. For instance, in studies of gay and bisexual men, associations have been found between CSB and minority stress processes, such as anti-LGBQ discrimination and rejection sensitivity (Pachankis, Rendina, et al., 2015; Rendina et al., 2017). These studies also report that emotion dysregulation mediates the association between minority stress and CSB, suggesting that CSB may emerge as a maladaptive coping response to the mental health consequences of minority stress.

Other literature suggests that minority stress may also be confused for CSBD symptoms among LGBQ clients and result in possible misdiagnosis (Jennings et al., 2022). For instance, one study found that LGBQ individuals were more likely to report self-perceived pornography addiction compared to their heterosexual counterparts, particularly at higher levels of internalized homonegativity (Droubay & White, 2023). This finding suggests that LGBQ clients experiencing internalized homonegativity (i.e., the application of societal homonegativity to the self) may label their same-gender sexual behavior as problematic or "addictive" because of stigma, rather than because they are experiencing CSBD symptoms.

Although additional research is needed, the studies reviewed above suggest that minority stress may cloud the accurate assessment of CSBD *and* contribute to the etiology of this condition among LGBQ clients. In line with this consideration, mental health professionals must skillfully distinguish between minority stress experiences that contribute to the development of CSBD symptomology and minority stress experiences that appear similar to CSBD symptoms but represent distinct sources of distress. Additionally, because minority stress may contribute to CSBD etiology, adapted therapeutic interventions addressing the specific needs of LGBQ clients may be critical for treating CSBD in this population. To address both needs, we provide assessment guidelines for distinguishing CSBD symptoms from the sociocultural context of LGBQ clients, as well as treatment recommendations for addressing CSBD symptoms that are rooted in minority stress.

CONDUCTING LGBQ-AFFIRMING ASSESSMENT FOR CSBD

The first step in providing affirming care to LGBQ clients with CSBD is to accurately assess whether they meet symptom criteria. However, there may be multiple factors compromising the accurate assessment of CSBD in LGBQ clients, including inadequate consideration of an LGBQ clients' sociocultural context and clinician stereotypes of LGBQ individuals. At present, more research has investigated these assessment considerations for borderline personality disorder compared to CSBD. For instance, research on assessment bias in diagnosing borderline personality disorder among LGBQ clients suggests that sociocultural factors, such as identity shifts (e.g., to hide sexual orientation in stigmatizing environments), may not be adequality distinguished from borderline personality symptoms, resulting in possible overpathologization (Eubanks-Carter & Goldfried, 2006; Rodriguez-Seijas, Morgan, & Zimmerman, 2021; Rodriguez-Seijas, Rogers, & Asadi, 2023). While more research is needed, similar concerns may arise in the assessment of CSBD among LGBQ clients. Below, we explicate how LGBQ-affirmative assessment would consider these possibilities before providing a CSBD diagnosis.

MINORITY STRESS AS A COMPLICATING FACTOR IN CSBD ASSESSMENT

LGBQ individual's experiences of minority stress might complicate the assessment of CSBD for several reasons. First, minority stress is a pervasive feature of LGBQ individuals' sociocultural context. Nearly all individuals with same-gender attractions or behaviors will be affected by such stress (Rodriguez-Seijas, Burton, & Pachankis, 2019). The pervasiveness of minority stress implies that it will be a commonly encountered clinical feature when working with LGBQ clients and may therefore need to be frequently considered in diagnostic decision-making. Second, minority stress experiences can resemble CSB. For instance, hiding one's sexual behavior may be either an indicator of CSB or a rational reaction to fear of identity-based rejection. Though these are two distinct functions of the same behavior (e.g., concealing one's sexual behavior), mental health professionals unfamiliar with minority stress may assume such behavior is an indicator of CSB. Third, minority stress is often insidious, and clients may find it difficult to identify the impacts of minority stress on themselves

(Rodriguez-Seijas, Burton, & Pachankis, 2019). For instance, clients who view their same-gender sexual interests as shameful may not readily attribute this shame to the internalization of societal homonegativity. Thus, the client's lack of awareness of the impact of minority stress could lead the clinician to inaccurately conclude that an LGBQ client's distress about their sexual behavior results from CSB.

Both distal (e.g., familial rejection) and proximal stress (e.g., internalized homonegativity) processes may complicate CSBD diagnosis and should be ruled out in the assessment process (see Table 1). For example, the distal stress process of familial rejection for being LGBQ may need to be distinguished from the CSBD symptom of repetitive engagement in sexual behavior despite adverse consequences, such as strained familial relationships. Although an LGBQ client may experience familial rejection due to CSBD symptoms, such rejection may also arise from discriminatory family attitudes directed toward an LGBQ client's sexual orientation. In the latter case, the distal stress process is the source of distress and impairment and should be ruled out in the assessment of CSBD.

Proximal stress processes may also complicate CSBD assessment. For instance, internalized homonegativity bears similarities to the moral incongruence rule-out for CSBD. This rule-out states that distress arising entirely from moral disapproval of one's own sexual behavior does not qualify for a diagnosis of CSBD (Grubbs, Floyd, Griffin, Jennings, & Kraus, 2022). Moral incongruence may appear as a specific manifestation of internalized homonegativity for LGBQ clients. For instance, a client may morally disapprove of their same-gender sexual attractions or behaviors and view themselves as having CSBD even when they do not meet symptom guidelines. In this case, moral incongruence (i.e., a specific manifestation of internalized homonegativity), should be ruled out in the assessment process because the client's distress is due to a proximal stress process rather than CSBD.

There is some evidence documenting moral incongruence in sexual minority men. A recent study found that moral incongruence predicted greater unhappiness among men who engaged in same-gender sex in the past year (Perry, Grubbs, & McElroy, 2021). That is, engaging in same-gender sexual behavior while simultaneously morally disapproving of that behavior was associated with greater unhappiness among men. Another study found that LGBQ individuals reported greater self-perceived pornography addiction compared to heterosexual individuals, particularly at higher levels of internalized homonegativity (Droubay & White, 2023). It is plausible that internalized homophobia is serving as a confounding factor and resulting in greater self-perceptions of sexual problems, even when CSBD symptoms are not present. Collectively, these findings suggest that internalized homonegativity, possibly in the form of moral incongruence, may *appear* as a symptom of CSBD in LGBQ individuals but must be ruled out in the diagnosis of this condition.

Table 1. Minority stress experiences resembling CSBD symptom guidelines (ICD-11)

CSBD symptoms (ICD-11)	Minority stress experiences resembling CSBD			
	Distal stress	Example	Proximal stress	Example
1A. Repetitive sexual behaviors are a central focus to the point of neglecting health or other activities	Familial rejection	Rejection from family toward an LGBQ clients same-gender sexual behaviors may result in neglect of health or other activities	Rejection hypervigilance	An LGBQ client may perseverate on being rejected by their family for their sexual orientation to the point of neglecting health or other activities
1B. The person has made numerous unsuccessful efforts to control or reduce repetitive sexual behavior	Institutional discrimination	A religious institution may label an LGBQ client's same-gender sexual behavior as problematic and recommend they reduce it through sexual orientation change efforts	Internalized homonegativity	LGBQ client efforts to reduce same-gender attractions or behavior may reflect internalization of stigma
1C. Engages in repetitive sexual behavior despite adverse consequences (e.g., relationship disruption)	Peer rejection	An LGBQ client's peers may reject them because they disapprove of the client's sexual orientation	Identity concealment	An LGBQ client might hide their sexual behavior to avoid rejection from their peers, which may lead to poorer relationships or other consequences
1D. Continues to engage in repetitive sexual behavior even when the individual derives little or no satisfaction	Familial rejection	Fear of familial rejection may lead an LGBQ client to engage in secretive, sexual encounters with same-gender partners that are unsatisfying	Internalized homonegativity	Internalized stigma may lead LGBQ clients to experience less sexual satisfaction in same-gender sexual encounters

Note. The examples of minority stress experiences in the present table are designed to resemble CSBD symptoms. These examples illustrate how mental health professionals may confuse minority stress experiences with CSBD symptom guidelines in the ICD-11. Minority stress experiences may be listed twice, given that such experiences may have several presentations resembling CSBD symptoms.

The confounding role of minority stress also raises concerns about the validity of CSB measures when used with LGBQ clients. That is, the instruments mental health professionals use to assess CSB may also be indexing minority stress, essentially conflating the two constructs. As an example, the Sexual Addiction Screening Test (Carnes, 1989) views secret sexual activities and outlets as indicators of sexual addiction. Similarly, the more recent Compulsive Sexual Behavior Inventory-13 (Miner, Raymond, Coleman, & Swinburne Romine, 2017) asks participants whether they conceal their sexual behavior as an indicator of CSB. However, as discussed, LGBQ clients may hide their sexual behavior because of a fear of discrimination (Moe, Finnerty, Sparkman, & Yates, 2015), rather than because of concerns about CSB. These problems make it difficult to know the degree to which current CSB measures index minority stress (e.g., internalized stigma) rather than, or in addition to, their intended construct (i.e., CSB; Jennings et al., 2022).

However, measurement invariance testing on measures of CSBD among LGBQ populations have been undertaken as part of a 42-country study on human sexuality (Bőthe, Koós, et al., 2021; Bőthe et al., 2023). According to recent measurement invariance testing, the original Compulsive Sexual Behavior Disorder Scale (Bőthe et al., 2020), as well as a short 7-item version, function similarly in LGBQ and heterosexual samples (Bőthe et al., 2023). Similarly, measurement invariance testing has been conducted on the Problematic Pornography Consumption Scale and Brief Pornography Screen, with results supporting the validity of these measures in sexual minority populations (Bőthe et al., 2024; Bőthe, Tóth-Király, Demetrovics, & Orosz, 2021; Bőthe, Vaillancourt-Morel, Dion, Štulhofer, & Bergeron, 2021). Although future research may identify ways in which minority stress confounds measurement of CSBD in LGBQ clients, these diagnostic instruments will ideally provide more valid measurement compared to existing instruments.

RULING OUT MINORITY STRESS IN CSBD ASSESSMENT

Reflecting the above concerns pertaining to minority stress, mental health professionals may encounter three broad presentations in the diagnosis of CSBD among LGBQ clients, as outlined by Jennings et al. (2022):

1. The LGBQ client meets CSBD criteria but does not present with minority stress experiences causing distress or impairment.
2. The LGBQ client does not meet CSBD symptom criteria but presents with minority stress experiences causing distress or impairment.
3. The LGBQ client meets CSBD symptom criteria and presents with minority stress experiences causing distress or impairment.

In presentation 1, mental health professionals may have greater confidence in providing a diagnosis of CSBD, given that minority stress is not a complicating factor. Presentation 2, however, may complicate diagnostic decision-making for mental health professionals, as there is a risk of conflating an LGBQ client's reported minority stress experiences with CSBD symptoms. This risk of conflation may be more likely if the presenting minority stress experiences bear strong resemblance to CSBD symptoms. Presentation 3 is perhaps the most complicated, given that some minority stress experiences may resemble but be unrelated to CSBD symptoms *and* other minority stress experiences may contribute to the etiology of CSBD.

To assist mental health professionals in diagnostic decision-making, we provide an assessment algorithm for distinguishing among each of these three presentations (see Fig. 1). The algorithm is only designed to help accurately *evaluate* for the presence of CSBD in LGBQ clients by distinguishing this condition from minority stress experiences. *Treatment* requires special consideration of how minority stress may also contribute to the development of CSBD symptomology, which is detailed later in this manuscript.

LGBQ STEREOTYPES AS A COMPLICATING FACTOR IN CSBD ASSESSMENT

Stereotypes of LGBQ people may also bias CSBD assessment. For instance, LGBQ people are often negatively stereotyped as being sexually promiscuous and having problematically high levels of sexual behavior (Geiger, Harwood, & Hummert, 2006; Pinsof & Haselton, 2016, 2017). Evidence suggests that mental health professionals may also hold these stereotypes (V. Klein, Briken, Schröder, & Fuss, 2019; Mohr, Chopp, & Wong, 2013; Prunas, Sacchi, & Brambilla, 2018) and that such stereotypes may impact CSBD diagnosis (V. Klein et al., 2019). One study found that mental health professionals from Germany, Austria, and parts of Switzerland rated vignettes of gay men and lesbian women as less likely to have CSB compared to heterosexual men and women, even when full CSBD symptom criteria were presented in the vignette (V. Klein et al., 2019). The authors theorized that gay men and lesbian women might be stereotyped as being more sexually active by mental health professionals, which may have led to perceptions of CSBD symptoms as more normative and less pathological in these clients. While effect sizes in this study were quite small, the results suggest that stereotypes mental health professionals hold may lead to under-diagnosis of LGBQ people with CSBD. Therefore, mental health professionals should critically reflect on whether stereotypes bias their assessment before diagnosing LGBQ clients with CSBD.

CONCLUDING LGBQ-AFFIRMING ASSESSMENT RECOMMENDATIONS FOR CSBD

Factors pertaining to the sociocultural context of LGBQ individuals may complicate the assessment of CSBD in LGBQ clients, including minority stress experiences and

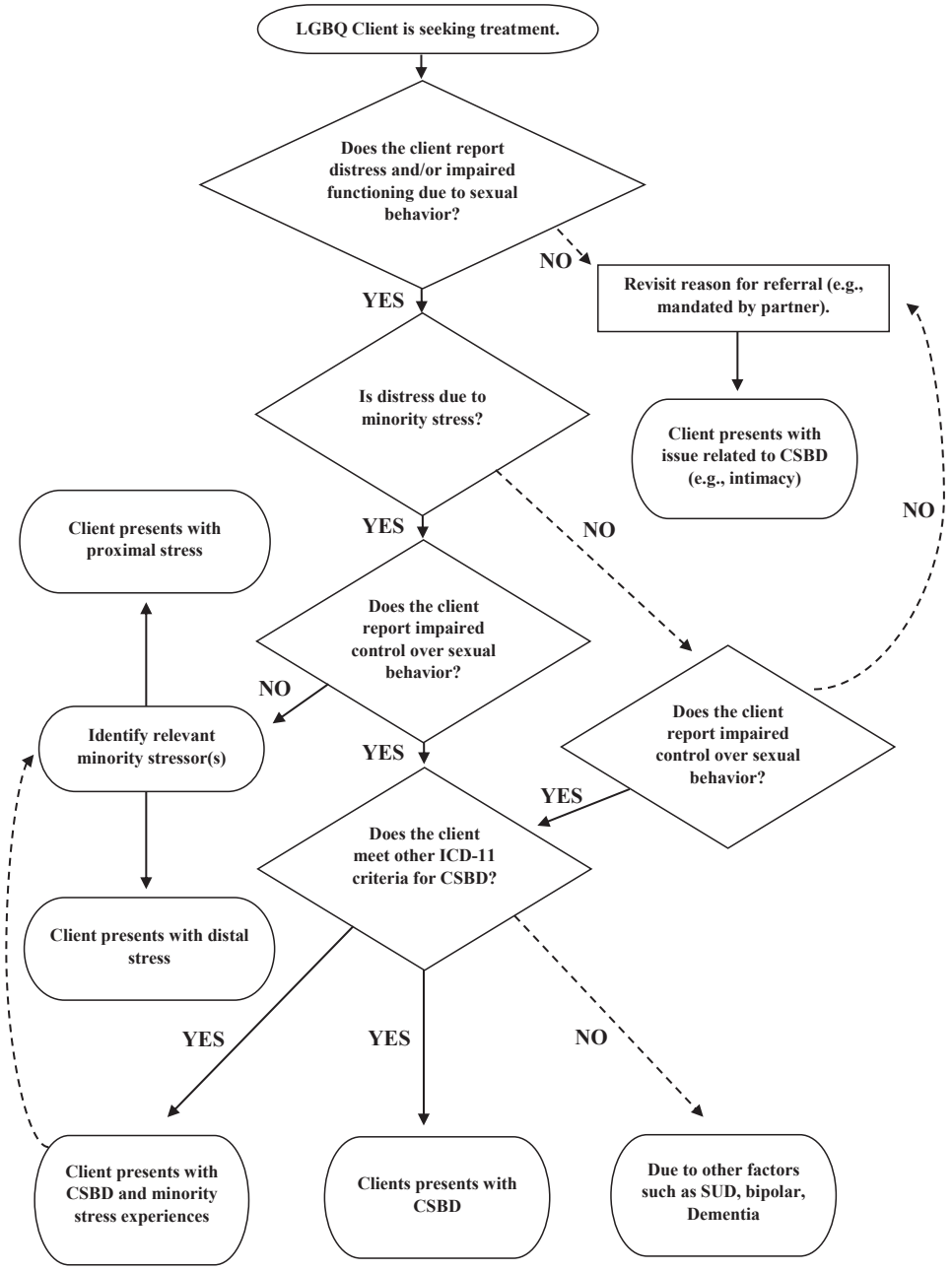

Fig. 1. CSBD assessment algorithm for LGBQ clients from Jennings et al. (2022)

stereotypes of LGBQ people. Notably, these complicating factors may arise from different sources: the client (e.g., perceiving oneself as a "sex addict" due to internalized homonegativity), the clinician (e.g., assuming that hiding one's sexual behavior is an indicator of CSBD in LGBQ clients), and the psychological measure (e.g., assessment instruments that do not distinguish between minority stress experiences and CSBD). We recommend reviewing each possible source of bias before diagnosing an LGBQ client with CSBD. Referencing Table 1 and using the assessment algorithm in Fig. 1 may help mental health professionals disentangle CSBD symptoms from minority stress experiences. Mental health professionals should also evaluate whether they hold any personal stereotypes that may lead to misdiagnosis of CSBD among LGBQ clients. Using the strategies discussed in this section may help clarify an LGBQ client's presenting concerns within their sociocultural context, protecting against the possibility of CSBD misdiagnosis as well as in guiding subsequent treatment decisions.

CONDUCTING LGBQ-AFFIRMING TREATMENT FOR CSBD

LGBQ-affirming interventions for CSBD may produce better treatment outcomes compared to non-adapted interventions intended for the general treatment-seeking population. As discussed, minority stress processes are theorized to result in

greater mental health concerns among LGBQ individuals (Brooks, 1981; Meyer, 2003). Given the growing empirical support for this position, minority stress experiences have recently been considered as treatment targets in the development of evidence-based interventions for LGBQ people (Pachankis, Soulliard, et al., 2022).

At present, LGBQ-affirmative cognitive-behavioral therapy (CBT) is the only treatment approach based on minority stress theory that has undergone testing in randomized controlled trials (Pachankis, Harkness, Jackson, & Safren, 2022). These trials suggest that LGBQ-affirmative CBT is efficacious in reducing sexual minority HIV-negative men's CSB, sexual risk behavior, depression, and alcohol use compared to waitlist controls (Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015), as well as sexual minority women's depression, anxiety, and alcohol use (Pachankis, McConocha, et al., 2020). A pilot study of LGBQ-affirmative CBT for gay and bisexual men who were HIV positive significantly reduced depression, anxiety, drug use, CSB, and HIV risk behavior (Parsons et al., 2017). LGBQ-affirmative CBT has also been culturally adapted to respond to distinct populations of sexually minority men, including Black and Latino gay and bisexual men in the United States (Jackson et al., 2022) and young Chinese gay and bisexual men (Pan et al., 2021). Moreover, a recent RCT comparing LGBQ-affirmative CBT to both LGBQ-affirmative counseling and HIV testing/counseling found a pattern of somewhat stronger effects across study outcomes: HIV-transmission risk behavior, depression, anxiety, substance use problems, and the co-occurrence of these mental and behavioral health concerns (Pachankis, Harkness, Maciejewski, et al., 2022). Collectively, these findings suggest minority stress as an important intervention target for LGBQ individuals.

LGBQ-affirmative CBT is based on a set of transtheoretical and transdiagnostic principles that can be flexibly incorporated into existing evidence-based interventions for a variety of a mental health conditions (Pachankis, Soulliard, et al., 2022). These principles were derived over several years from in-depth interviews and consultations with expert treatment providers and community stakeholders in a multistage process (Pachankis, 2014; Scheer, Clark, McConocha, Wang, & Pachankis, 2022). The principles are considered transdiagnostic because they have been argued to theoretically address any mental or behavioral health outcome in which minority stress might play a role (Pachankis, Soulliard, et al., 2022). The principles are also transtheoretical, meaning they can be flexibly incorporated into varying evidence-based practice modalities, such as cognitive behavior therapy and acceptance and commitment therapy. While past work has explicated these principles in detail (Pachankis, 2014) and found support for these approaches in reducing CSB (Pachankis, Hatzenbuehler, et al., 2015; Parsons et al., 2017), the principles have yet to be fully considered in the context of the broader CSB literature. Therefore, we integrate the LGBQ-affirming treatment principles with the CSB research literature to further clarify their application in the treatment of CSB.

PRINCIPLE 1: HIGHLIGHT HOW MENTAL AND BEHAVIORAL HEALTH CHALLENGES CAN BE NORMAL RESPONSES TO MINORITY STRESS

The first principle outlined by Pachankis, Soulliard et al. (2022) discusses how mental and behavioral health challenges are normal responses to minority stress for LGBQ clients. We contend that LGBQ clients with CSBD may likewise benefit from considering how their symptoms are normal responses to minority stress. A large literature describes that a core feature of CSB involves using sex maladaptively to cope with negative mood states, such as depression and anxiety (Gola et al., 2020; Lew-Starowicz, Lewczuk, Nowakowska, Kraus, & Gola, 2020). This feature is likely present in many LGBQ clients with CSBD as well (Pachankis, Rendina, et al., 2015; Parsons et al., 2008). For instance, in a qualitative study of 180 gay and bisexual men who were presenting with CSB, several indicated engaging in sexual behavior to cope with negative mood states (Parsons et al., 2008). Additionally, multiple studies provide evidence that emotion dysregulation mediates the association between minority stress experiences and CSB, suggesting that minority stress contributes to emotion dysregulation and subsequent engagement in CSB as a maladaptive coping response (Cienfuegos-Szalay, Moody, Talan, Grov, & Rendina, 2022; Pachankis, Rendina, et al., 2015; Rendina et al., 2017).

However, many LGBQ clients may not be aware of the connection between minority stress and their engagement in CSB (Parsons et al., 2008). Principle 1 may therefore involve working with LGBQ clients to foster an awareness of the connections between their minority stress experiences and CSB symptoms. For instance, engaging in CSB may be one way an LGBQ client avoids negative emotions associated with a history of family estrangement and peer rejection directed toward their LGBQ identity during childhood (Pachankis, Rendina, et al., 2015). Helping LGBQ clients notice the connections between minority stress and their engagement in CSB may be helpful for ameliorating self-blame and promoting more adaptive perspectives on the source of their symptoms. Principle 1 may be best addressed earlier in treatment to help clients understand their presenting concerns, especially for those who tend to blame themselves for their CSBD symptoms.

PRINCIPLE 2: ACKNOWLEDGE HOW EARLY AND ONGOING EXPERIENCES WITH MINORITY STRESS CAN TEACH SEXUAL MINORITY INDIVIDUALS POWERFUL, NEGATIVE LESSONS ABOUT THEMSELVES

The second principle outlined by Pachankis, Soulliard et al. (2022) acknowledges how early and ongoing minority stress experiences can have an enduring impact on LGBQ people's self-concept and mental well-being. Similarly, the CSBD

research literature has identified that early experiences with attachment figures contribute to the development of CSBD symptoms (Efrati, Kraus, & Kaplan, 2021; Lew-Starowicz et al., 2020). Both anxious attachment (i.e., nervousness, anxiety, and concerns with rejection in relationships) and avoidant attachment (i.e., avoidance of close attachment and a preference for independence) have been associated with CSB (Coleman et al., 2022; Weinstein, Katz, Eberhardt, Cohen, & Lejoyeux, 2015). Insecure attachment is theorized to compromise emotion regulation abilities, ultimately contributing to greater CSB symptoms (Coleman et al., 2022; Lew-Starowicz et al., 2020). While little research has examined whether attachment concerns are more prevalent in LGBQ people relative to heterosexual individuals, some research has found that LGBQ populations report greater insecure attachment, especially for those who display greater gender nonconformity (Landolt, Bartholomew, Saffrey, Oram, & Perlman, 2004; Nematy & Oloomi, 2016; Shenkman, Bos, & Kogan, 2019). LGBQ individuals may be especially prone to developing insecure attachment styles because peer and parental rejection often occur at an early age among LGBQ youth (D'augelli, 2002; Katz-Wise, Rosario, & Tsappis, 2016). These stigmatizing contexts endured by LGBQ youth may be further compounded by an awareness that their identity exists in relative isolation due to the absence of adult LGBQ figures in their lives (Pachankis et al., 2021; Pachankis & Jackson, 2022).

The absence of stable relationships in the early lives of LGBQ people may lead to the development of an insecure attachment style and unhealthy cognitive patterns that subsequently result in the development of CSBD later in life. For instance, familial and peer-rejection may lead to social withdrawal, negative self-perceptions, and anxious expectations of rejection, which have, in turn, been associated with negative mood states, unassertiveness, substance use, and CSB (Pachankis, Rendina, et al., 2015). Therefore, mental health professionals assessing attachment and relationship quality among LGBQ individuals with CSBD should consider how minority stress may have shaped their early life context. Tracking how early and ongoing minority stress experiences may have led to disempowering cognitive patterns, such as thoughts of inferiority or low self-worth, may provide insight into the origins of an LGBQ client's CSBD symptoms. This information may further help the clinician and client appropriately attribute the source of their distress to minority stress instead of personally disempowering beliefs.

PRINCIPLE 3: EMPOWER SEXUAL MINORITY INDIVIDUALS TO EFFECTIVELY COPE WITH THE UNFAIR CONSEQUENCES OF MINORITY STRESS

The third principle outlined by Pachankis, Soulliard et al. (2022) highlights opportunities to help LGBQ clients cope with the consequences of minority stress. As discussed, engaging in CSB may be a maladaptive coping mechanism for LGBQ clients who experience negative mood states (Parsons et al., 2008). Minority stress experiences are at least partially responsible for diminishing an LGBQ client's ability to adaptively cope with stress (Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009). Indeed, emotion regulation difficulties serve as a mediator between minority stress experiences and negative mood states (Hatzenbuehler et al., 2009) and may serve a similar function in driving CSB (Pachankis, Rendina, et al., 2015). LGBQ people who experience minority stress are more likely to develop universal psychological vulnerabilities that subsequently contribute to greater vulnerability for mental health problems, including CSB. This point is consistent with studies suggesting that difficulties with coping are prominent in CSB presentations among LGBQ clients (Parsons, Kelly, Bimbi, Muench, & Morgenstern, 2007, 2008).

Difficulties with coping might lead LGBQ clients to engage in sexual behaviors associated with a short-term reduction in negative mood states, even if they generate longer-term distress. Over time, engaging in CSB to avoid painful emotions associated with minority stress may prevent exposure to negative mood states and their ultimate alleviation (Pachankis, Harkness, Maciejewski, et al., 2022). Intentional exposure to negative mood states that emerge in response to minority stress can represent empowered coping, as one intentionally faces the negative mood in search of more adaptive behavioral responses. Therefore, a natural point of intervention for CSB would be to raise LGBQ clients' awareness of the role of minority stress in one's experience of negative emotions and avoidant behavioral responses, such as CSB, while also instilling behavioral repertoires that promote coping self-efficacy.

PRINCIPLE 4: HELP SEXUAL MINORITY INDIVIDUALS BUILD SUPPORTIVE, AUTHENTIC RELATIONSHIPS

The fourth principle outlined by Pachankis, Soulliard et al. (2022) recognizes that LGBQ individuals often have greater difficulties accessing supportive, authentic relationships in their lives. As discussed above, anxious and avoidant attachment are notable contributors to the development of CSB (Efrati et al., 2021; Lew-Starowicz et al., 2020; Weinstein et al., 2015). Additionally, compared to heterosexual people, LGBQ individuals are especially likely to experience social isolation, have fewer social supports, and experience rejection by family and peers (D'augelli, 2002; Katz-Wise et al., 2016; Pachankis et al., 2021; Pachankis & Jackson, 2022). These concerns can occur early in life, but may also occur throughout the lifespan (Pachankis, Clark, et al., 2020). Lack of social support among LGBQ people has been linked to greater mental health concerns (Hatzenbuehler et al., 2012) and may be a contributor to greater CSBD. For instance, one study found that gay and bisexual men with CSB report engaging in sexual behavior for

validation and affection, even though many participants described that these encounters did not address their needs and often made them feel worse (Parsons et al., 2008). Helping LGBQ clients build relationships that provide validation and affection, even if not in a sexual context, may help address otherwise unmet needs that are driving CSB.

PRINCIPLE 5: HIGHLIGHT SEXUAL MINORITY INDIVIDUALS' UNIQUE STRENGTHS

The fifth principle outlined by Pachankis, Soulliard et al. (2022) capitalizes on the unique strengths of LGBQ communities. Highlighting these strengths may help develop a client's self-esteem and positive feelings toward being a sexual minority person (Herrick, Stall, Goldhammer, Egan, & Mayer, 2014; Meyer, 2015; Perrin, Sutter, Trujillo, Henry, & Pugh, 2020). For instance, the LGBQ community demonstrates strength in having to endure discrimination in society and engage in activism related to sexual health (Trapence et al., 2012), and in the efforts among sexual minority women to challenge patriarchal norms (Riggle, Whitman, Olson, Rostosky, & Strong, 2008). On a more individual level, each LGBQ person navigates a complex coming out process with unique challenges and insights (Pachankis & Jackson, 2022).

While little research has considered how positive aspects of being an LGBQ person may be related to CSBD, there is good theoretical reason to think that such strengths may serve as protective factors against the development of this condition. As an example, resilience involving LGBQ community-building may provide greater self-esteem and connections to authentic, validating relationships that reduce engagement in CSB. Engagement in non-sexual prosocial behaviors with other LGBQ people may introduce an LGBQ client to the identity-validating benefits of belonging to a community. This community belonging might fulfill similar needs (e.g., validation, pride) as CSB but without the distressing consequences.

PRINCIPLE 6: UNDERSTAND INTERSECTING IDENTITIES AS A SOURCE OF STRESS AND RESILIENCE

The sixth principle outlined by Pachankis, Soulliard et al. (2022) discusses how intersectionality may impact the treatment process for LGBQ clients, as sexual orientation often overlaps with several other salient identities (e.g., race, socioeconomic status, and ability; Crenshaw, 2018). While there may be notable sources of stress and resilience at the intersection of various identities, the CSBD research literature has seldom considered this possibility (Grubbs et al., 2020; Jennings, Lyng, Gleason, Finotelli, & Coleman, 2021, 2022). For instance, LGBQ people of color often experience racialized sexual discrimination (i.e., the sexual and romantic rejection of people who are members of certain racial groups; Han, 2007), which may drive CSBD symptoms. Past research indicates that sexual minority men of color, particularly Black and Asian men, are more likely to experience sexual or romantic rejection based on their race compared to White sexual minority men (Callander, Holt, & Newman, 2016; Gleason, Serrano, Muñoz, French, & Hosek, 2022; Han & Choi, 2018). Recent research found that aspects of racialized sexual discrimination were associated with lower self-esteem and, in turn, lower life satisfaction (Thai, 2020). Perhaps experiences of racism may also contribute to the etiology of CSBD among sexual minority men of color by eroding adaptive coping mechanisms. Although additional research is needed to evaluate such possibilities, this principle encourages mental health professionals to consider the unique experiences of LGBQ individuals who hold several marginalized identities.

Notably, this principle modifies the first five, as mental health professionals should be considerate of intersectionality throughout their work with clients (Pachankis, Soulliard et al., 2022). For instance, mental health professionals should help clients develop an awareness of how intersectional manifestations of minority stress might impact their CSBD symptoms (Principle 1), explore how intersectional minority stress may have uniquely shaped a client's cognitive processes (Principle 2), and consider interventions that help clients with intersecting identities adaptively cope with the unfair consequences of minority stress (Principle 3). Lastly, mental health professionals should focus on helping their clients foster authentic relationships that validate their multiple marginalized identities (Principle 4) and explore the resilience afforded by possessing multiple minoritized identities (Principle 5; Bowleg, 2013; Ghabrial, 2017; Jackson, Mohr, Sarno, Kindahl, & Jones, 2020).

FUTURE RESEARCH RECOMMENDATIONS TO ENHANCE UNDERSTANDING OF CSBD IN LGBQ CLIENTS

This section provides research recommendations to enhance scientific understanding of CSBD in LGBQ clients. Future assessment research should evaluate possible sources of bias that complicate the accurate diagnosis of CSBD among LGBQ clients, such as measurement and clinician bias. While the present paper provides assessment guidelines for distinguishing the sociocultural contexts of LGBQ people from CSBD symptoms, several questions remain about how often misdiagnosis might occur in varied clinical or cultural contexts. For instance, certain mental health professionals may display greater bias than others in the diagnosis of CSBD in LGBQ clients (e.g., 12-step providers vs. sex therapists). Additionally, LGBQ individuals in conservative cultures with high degrees of structural stigma (e.g., laws that ban same-gender marriage or imprison individuals for same-gender sexual behavior) may be more likely to attribute the source of their distress to their sexual behavior instead of their stigmatizing sociocultural context.

This possibility merits further examination, as mental health professionals working with LGBQ clients in conservative cultures might see greater degrees of internalized homophobia, identity concealment, and other forms of minority stress that complicate CSBD assessment (Pachankis et al., 2021).

Future treatment research could adapt and test several evidence-based interventions for CSBD to be LGBQ-affirming. These interventions could be compared to determine whether certain modalities exhibit greater efficacy. Treatment research should also examine LGBQ-affirming interventions in other diverse populations, including transgender individuals, queer people in conservative cultures, and LGBQ clients with intersectional identities.

In addition to researching LGBQ-affirming assessment and treatment, consideration should also be given to whether LGBQ clients with CSBD display unique clinical characteristics compared to heterosexual clients. For instance, problematic pornography use is currently thought to be the most common behavioral manifestation of CSBD, with some research suggesting it represents up to 81% of diagnosable cases (Reid et al., 2012). However, this finding is primarily based on samples of heterosexual men and may not generalize to members of LGBQ populations who often report having different sexual experiences relative to their heterosexual counterparts, such as entering an open relationship involving sex with multiple partners (E. C. Levine, Herbenick, Martinez, Fu, & Dodge, 2018), using dating

Table 2. Areas for future investigation

	Future research directions
Assessment bias	Assessment research should evaluate sources of bias that may confound the accurate diagnosis of CSBD for LGBQ clients
Client bias	Examine connections between moral incongruence of one's own same-gender sexual behavior, self-perceptions of addiction, internalized homophobia, religion, and CSBD
Measurement bias	Research whether participant responses on measures of CSBD capture LGBQ-related stress (i.e., minority stress) or actual CSBD symptoms
Clinician bias	Determine whether certain mental health professionals (e.g., sex therapists, 12-step providers) are more likely to exhibit bias in diagnosing CSBD in LGBQ clients
Treatment	Treatment research should evaluate the efficacy of LGBQ-affirming interventions that address minority stress and client and clinician perceptions of such treatments
Efficacy	Conduct randomized controlled trials comparing LGBQ-affirming interventions for CSBD compared to non-adapted treatments (e.g., HIV testing and counseling)
Therapeutic modality	Adapt and test several evidence-based interventions to be LGBQ-affirming and compare the benefits and costs of each therapeutic modality
Clinician and client perceptions	Examine the perceptions of mental health professionals in implementing LGBQ adapted interventions, as well as client perceptions in receiving adapted care
Diversity	Diversity research should evaluate the generalizability of CSBD research to gender and sexual minority clients, including those with intersecting identities (e.g., race, ability)
Generalizability	Determine whether research findings are applicable in diverse populations using targeted sampling and advanced research techniques (e.g., measurement invariance)
Gender diversity	Evaluate the specific assessment and treatment needs of transgender and gender diverse clients with CSBD, as CSBD research has historically ignored these populations
Intersectionality	Examine the unique experiences of LGBQ clients with intersecting identities who have CSBD, such as gay men of color who experiencing racialized sexual discrimination
Cultural diversity	Research whether LGBQ clients in more conservative cultures present with unique CSBD presentations relative to LGBQ clients in less conservative cultures
Clinical characteristics	Research on clinical characteristics should evaluate whether LGBQ clients tend to have unique CSBD symptom presentations requiring notable treatment adaptations
CSBD manifestations	Evaluate whether certain behavioral manifestations of CSBD (e.g., partnered sex) are more common among LGBQ clients compared to their heterosexual counterparts
Sexual risk behavior	Identify whether LGBQ clients are more likely to endorse CSBD manifestations that are more sexually risky compared to heterosexual clients (e.g., unprotected anal sex)
Dating applications	Examine possible ways that dating applications may facilitate an LGBQ client's access to sexual encounters and, consequently, intensification of CSBD symptoms
Comorbidity	Research on comorbid conditions should focus on whether CSBD often co-occurs with sexualized drug use, chemsex, and other conditions among LGBQ clients
Substance use	Determine whether LGBQ people with CSBD are more likely to engage in sexual behavior while under the influence of a substance compared to those without CSBD
Chemsex	Examine whether chemsex often co-occurs with CSBD in LGBQ populations and develop specific clinical recommendations for addressing this specific presentation
Other comorbidities	Consider whether other conditions may be more or less likely to co-occur with CSBD in LGBQ populations relative to heterosexual individuals, such as gambling disorder

applications to find sex (Anzani, Di Sarno, & Prunas, 2018), having increased risk for acquiring a sexually transmitted infection (Johnson Jones et al., 2019), and participating in substance use during sexual activity (Berg, Amundsen, & Haugstvedt, 2020). Differences in the sexual behaviors and experiences of LGBQ and heterosexual people may also be reflected in the behavioral manifestations of CSBD reported across these populations.

Substance use during sex, including chemsex, may be an especially relevant clinical feature for some LGBQ clients presenting with CSBD, particularly sexual minority men. Chemsex refers to the use of specific drugs (e.g., methamphetamine, ecstasy, GHB) before or during sex to facilitate, enhance, and prolong sexual encounters and is often found to be more common among sexual minority men compared to heterosexual men (Berg et al., 2020). Perhaps chemsex commonly co-occurs with CSBD among sexual minority men, resulting in more severe clinical presentations. Given that chemsex among sexual minority men has been linked to severe psychological distress, psychosis, depression, anxiety, and long-term memory loss (Bourne et al., 2015; Dearing & Flew, 2015; Dolengevich-Segal, Rodríguez-Salgado, Gómez-Arnau, & Sánchez-Mateos, 2016), its co-occurrence with CSBD likely requires additional assessment and treatment consideration. Future research might consider how often chemsex and CSBD co-occur and whether their co-occurrence is associated with poorer mental health.

Another important consideration for research is whether specific minority stress processes are more closely associated with CSBD. Some studies suggest internalized homonegativity may be more strongly associated with CSBD compared to rejection sensitivity (Pachankis, Rendina, et al., 2015; Rendina et al., 2017); however, additional research is needed to compare the strength of the connection between CSBD and other minority stress processes, such as structural stigma. Future research could pinpoint the minority stress processes bearing the strongest relationships with CSBD and investigate whether such processes are confounding accurate measurement of CSBD or contributing to its etiology.

Lastly, future research is needed to examine CSBD in various LGBTQ populations. Most research on CSB among LGBTQ populations uses samples of sexual minority men, which substantially limits understanding of this condition in other members of the LGBTQ community (Grubbs et al., 2020; Jennings et al., 2022). Additionally, research is needed to consider possible differences in CSBD across various facets of sexual orientation (Laumann, Gagnon, Michael, & Michaels, 2000), such as sexual identity (e.g., identifying as bisexual or lesbian) and sexual behavior (e.g., engaging in same-gender sexual behavior). Although sexual identity and behavior often align (e.g., a gay man who is attracted to and has sex with men), exceptions are common (e.g., a heterosexual identified man who reports attractions to and sexual behavior with men). Perhaps individuals who identify as heterosexual, but report having sex with someone of the same gender, would be more likely to experience internalized homonegativity, moral incongruence, and, subsequently, *self-perceived* CSBD.

Answers to several of these promising areas of empirical investigation remain tentative and future research will be necessary to enhance understanding of CSBD in LGBQ clients. Additionally, the LGBQ-affirming assessment and treatment recommendations in this paper are presented with the qualification that future research is needed to verify their efficacy or relevance for LGBQ clients with CSBD. Table 2 presents a summary of the research recommendations discussed above, as well as several other research considerations.

CONCLUSION

The present paper provides mental health professionals with actionable, empirically based assessment and treatment recommendations derived from a synthesis of the CSBD and LGBQ-affirming research literatures. The assessment considerations highlight how aspects of the sociocultural context of LGBQ clients, particularly minority stress processes, may be confused for actual symptoms of CSBD. Before diagnosing an LGBQ client with CSBD, mental health professionals should rule out any confounding factors pertaining to an LGBQ client's sociocultural context. The treatment considerations encourage mental health professionals to consider how minority stress processes may also be etiological factors in the development of CSBD. Treatment principles are provided that could help guide mental health professionals in their work with LGBQ clients who are struggling with CSBD. While future research will be critical toward optimizing LGBQ-affirming care for CSBD, the guidelines in the present paper represent a starting point for mental health professionals working with LGBQ clients presenting with this condition.

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