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Debate: Behavioral addictions in the ICD-11

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COMMENTARY



Mental and sexual health perspectives of the International Classification of Diseases (ICD-11) Compulsive Sexual Behavior Disorder

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

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ABSTRACT

After introduction of compulsive sexual behavior disorder (CSBD) in the ICD-11, many questions regarding etiology, classification and diagnostic criteria remain unanswered, providing rationale for further research. In this commentary, we critically review the ongoing discussion reflected in some relevant articles, and try to point out the risks of oversimplification of the broad clinical phenomenon, as well as attract attention to the neglected aspects, such as psychosexual development, intimacy disorder and the role of sexological expertise in the assessment and treatment of individuals presenting with out-of-control sexual behaviors. We also advocate for multimodal, transtheoretical approach and suggest that CSBD may be reconsidered as a condition related to sexual health.

KEYWORDS

compulsive sexual behavior, diagnostic criteria, sexual addiction, hypersexual impulse control, emotion dysregulation

Recognizing compulsive sexual behavior disorder (CSBD) as a distinct disorder in the ICD-11 (WHO, 2018) is a great step forward after decades of debate on the clinical syndrome of out-of-control sexual behavior and the more recent rejection of hypersexual disorder (HD), the proposed diagnosis in the DSM-5 (Kafka, 2010; 2014). The inclusion of CSBD in the ICD-11 is expected to greatly improve treatment access and stimulate further research. The way CSBD was defined and placed in the classification of mental disorders may be perceived as a compromise between different conceptualizations of this clinical syndrome as an impulse control disorder, obsessive-compulsive disorder, non-paraphilic hypersexual disorder, behavioral addiction or sexual disorder. However, given this compromise and the heterogeneity of CSBD clinical presentations and uncertainties regarding the accuracy of epidemiological, psychological and neurophysiological studies in relation to CSBD, debates regarding diagnostic classification and diagnostic criteria certainly will continue and these debates are important to further elucidate this clinical phenomenon. These debates are well articulated by the three recently published articles by Brand et al. (2022), Gola et al. (2022) and Sassover and Weinstein (2022).

These papers articulate the problems with the current diagnostic guidelines and suggest further research that is needed to bring about better clarity about the clinical phenomenon and appropriate classification and understanding of the etiological and comorbid factors. While Brand et al. (2022) argue that many of the clinical presentations could fit into the ICD-11 category of disorders due to addictive behavior, Sassover and Weinstein (2022) argue that seeing this as an addictive disorder is clearly premature and point out that there is too much heterogeneity to reduce the phenomenon into one type of disorder and not appreciate

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the varying degrees of impulsiveness, compulsiveness, and other pathophysiological factors. [Gola et al. \(2022\)](#) are in agreement and they outline the many issues that need to be resolved in order to bring about better diagnostic clarity.

There is a fair degree of agreement among the various authors regarding the following issues:

1. CSBD is a newly defined clinical phenomenon that deserves much greater attention. Where and how it should be classified is a matter of debate and in need of further study.
2. The clinical entity involves diminished control over sexual behavior and causes functional impairment.
3. Any classification and diagnostic criteria should ensure that this is distinct from other clinical entities that would better explain the pathophysiology.
4. There is concern about over-pathologizing normative sexual behavior.
5. There is a need of further research, including better instrumentation, clinical assessment, examining fundamental aspects of clinical entities within this population and probably the recognition of different types or subtypes given the heterogeneity of dynamics that are involved in presenting symptoms and the need to find a cohesive diagnostic category and criteria.

There are some other issues which some of the authors have pointed out:

1. The role of emotion regulation needs to be resolved as a fundamental component of criteria or whether emotion dysregulation is a precipitating or perpetuating factor. Sexual behavior as coping strategy to deal with negative mood states has been already emphasized in various models of compulsive sexual behavior ([Braun-Harvey & Vigorito, 2015; 1991](#)) or in the conceptualization of HD proposed by [Kafka \(2010\)](#) for DSM-5. [Gola et al. \(2022\)](#) reflects that it is not entirely clear why emotion regulation related or stress-proneness criteria were excluded from the ICD-11 guidelines for CSBD as an essential feature, as there is large amount of data showing that CSBD is often associated with using sex to cope with difficult emotions, stress or painful experiences ([Miner, Dickenson, & Coleman, 2019; Reid, Carpenter, Spackman, & Willes, 2008; Reid, Stein, & Carpenter, 2011; Lew-Starowicz, Lewczuk, Nowakowska, Kraus, & Gola, 2020](#)). It is recognized as an “additional clinical feature” ([WHO, 2022](#)).
2. There is a need to examine the criteria of moral incongruence more closely. In particular, [Gola et al. \(2022\)](#) discusses the uncertainties of using moral incongruence as an exclusion criterion of CSBD. Moral incongruence determined by the cultural milieu, religious beliefs and individual upbringing clearly affects the propensity to seek treatment. It has not been considered exclusionary for gambling disorder nor substance addictions. Some of treatment-seeking individuals who report problems with pornography due to moral incongruence meet the ICD-11 guidelines for CSBD diagnosis while the others do not. Differential diagnosis between these two presentations should lead to a different treatment approach as pointed out by [Kraus and Sweeney \(2019\)](#). Therefore,

feelings of moral incongruence towards excessive erotica viewing should not arbitrarily disqualify an individual from receiving a diagnosis of CSBD and its role in the etiology of and definition of CSBD warrants additional understanding ([Gola et al., 2022](#)).

3. The need to explore whether or not tolerance or withdrawal is part of the clinical phenomenon. [Sassover and Weinstein \(2022\)](#) point out insufficiency of evidence-based data that would advocate recognition of CSBD as behavioral addiction. They argue that phenomenological studies do not cover all the components of the addiction model by [Griffiths \(2005\)](#) which were endorsed in the DSM-5 for gambling addiction. Further, the ICD-11 definition also does not require withdrawal symptoms nor tolerance. They claim there is no methodological evidence for the existence of tolerance mechanism among CSBD patients.
4. The need to explore whether a specific clinical presentation - problematic pornography use or pornography use disorder - may better fit to the addiction framework under “other specified disorders due to addictive behaviors” in the present ICD-11 framework ([Brand et al., 2022](#)). They suggest that CSBD diagnosis may be more appropriate for individuals who not only use pornography compulsively, but who also suffer from other non-pornography-related compulsive sexual behaviors (masturbation or other sexual activities, including partnered sex).
5. In the proposed hypersexual disorder criteria, decreased satisfaction was an essential criteria. People with CSBD often describe decreased satisfaction, guilt and remorse over their sexual behavior. It has been suggested that this should be revisited ([Sassover & Weinstein, 2022](#)).
6. Once some diagnostic criteria is established, there is a need for better epidemiological data – particularly noted by [Sassover and Weinstein \(2022\)](#).

Our concerns are:

1. We appreciate the guidance that the authors have made about the future research that is needed. Moreover, when the definition and diagnostic guidelines of CSBD are implemented worldwide, more research should be dedicated to evaluate different treatments of individuals with this new diagnostic category and using measures adapted to clinical diagnostic criteria.
2. We certainly agree with [Sassover and Weinstein \(2022\)](#) that classifying CSBD as a behavioral addiction is premature - if not quite problematic.
3. There are clear limitations of recognizing CSBD both as an impulse control disorder or as a disorder due to addictive behavior. [Brand et al. \(2022\)](#) pointed out the risk of over-pathologizing everyday behaviors and that it is important to distinguish frequent behavioral engagement from a behavioral pattern that fulfills the criteria for addiction. However, even the idea of assigning problematic pornography use (PPU) or pornography use disorder (PUD) to the addiction framework is not sufficiently evidenced, as studies on PPU/PUD commonly do not exclude subjects who masturbate while watching pornography, so the findings are not representative for “porn addiction.”

4. [Sassover and Weinstein \(2022\)](#) suggest that moving gambling disorder to 'addictive disorders' in the DSM-5 resulted in less restrictive diagnostic criteria and opening a space for more subjective interpretation of the assessor, as well as self-report-related bias. One may assume that moving CSBD to 'disorders due to addictive behavior' may also lead to an overestimation of hypersexual behavior.
5. The addiction or impulse control or any other clinical paradigm risks over-simplification of the broad clinical phenomenon and there are dangers in applying known effective treatments for other types of disorders to this sexual disorder, certainly without careful treatment protocols and outcome studies. For example, the wholesale adaptation of the alcohol or drug treatment model, which tends to emphasize abstinence, to the treatment of compulsive sexual behavior is particularly concerning.
6. In line with [Gola et al. \(2022\)](#), we also foresee the risk of under-estimating and under-recognizing dysregulation of emotion in future studies that will focus on the ICD-11 definition. From a holistic, therapeutical perspective, it seems also very important to understand and address emotional underpinnings of the dysregulation of sexual drive in order to counterbalance control- and harm reduction-focused behavioral approaches.
7. Besides a lack of control of sexual behavior, it seems clear that CSBD deeply affects sexual wellbeing and the ability to form and maintain satisfactory emotional and sexual relationships. In most individuals an individual's psychosexual development and regulation of sexual behavior becomes dysregulated. Thus, it is our belief that this is best conceptualized as a sexual disorder. Using a transtheoretical approach, it might be most appropriate to consider classifying CSBD in the ICD-11 in Chapter 17 "Conditions related to sexual health" along with the other sexual dysfunctions and disorders. This debate is well illustrated in the cited articles.
8. While all the authors debate whether this is an addictive, sensation seeking, emotion regulation, impulsive, or compulsive disorder, they fail to consider this as a sexual disorder. Sexual disorders are now classified outside of the mental disorders section ([WHO, 2018](#)), recognizing the false distinction between mind and body and the heterogeneous etiological pathways to these syndromes.
9. Instead of single-theory conceptualizations, we are much more in line with transtheoretical and multimodal approach for better understanding of the nature and providing individualized treatment of variant out-of-control sexual behaviors ([Briken, 2020](#); [Coleman et al., 2018](#); [Lew-Starowicz & Gola, 2020](#)). From the sexological perspective, impulsive and compulsive sexual behavior might be seen as identity and intimacy disorder that occurs within nested contexts, which constitute an interplay of physiological, genetic, social, cognitive, emotional and cultural influences over time ([Coleman et al., 2018](#)). We believe that this perspective would better advocate non-judgmental attitudes among clinicians and a sex-positive approach, understanding sexual diversity and identifying individual mechanisms that result in loss of control over sexual behavior, related distress and negative consequences. This would translate into broadened therapeutic goals including development or restoring healthy sexuality and relationships instead of focusing on behavioral control and preventing from negative consequences.
10. Further, the field of sexual health and medicine recognizes that there is a particular knowledge and skills set needed to address these concerns, including a foundational understanding of the nature of human sexuality, its diversity, and factors in sexual development. Given both sexuality-related origins and consequences of CSBD, as well as the need of a sociocultural-sensitive assessment, it seems that diagnosing and treating CSBD demands an expertise in clinical sexology or sexual medicine.
11. As mental health professionals and sexologists who view sexual problems from an interdisciplinary perspective, including the influence of socio-cultural factors, we welcome the perspectives from other fields of psychology and psychiatry, but we feel the sexological perspective is often missing from these debates. And, indeed, we need consultation with other clinical specialists. This is the same way as we do not pretend to diagnose or treat substance use, gambling, eating, or other types of problematic behaviors unless we have received in-depth training in those particular types of clinical disorders. We have been concerned about the possible lack of sexological training among people who will be treating compulsive sexual behavior disorder.

CONCLUSION

Clinicians are commonly confronted with complaints on out-of-control sexual behavior and negative consequences, and faced with a challenge to recognize underlying mechanisms and formulate proper diagnosis in order to provide the patient with the most effective therapy (although there are no widely accepted treatment guidelines yet). Despite debates among experts regarding diagnostic classification and diagnostic criteria will certainly continue, further research should focus on expanding the knowledge of specific pathophysiological mechanisms involved in particular manifestations of CSBD and clinical features in less explored populations, including women and sexual minorities. While ongoing considerations on compulsive sexual behavior as addiction or impulse control disorders might be seen as a step backwards, more attention should be given to further explore the neurocognitive, affective (dysregulation of emotion), interpersonal (attachment issues, sexual trauma), and the role of religiosity and moral incongruence aspects of this clinical phenomenon. Different treatment modalities are awaiting evaluation based on newly introduced diagnostic criteria and matched instruments such as CSBD-19 ([Bóthe et al., 2020](#)). Given the heterogeneous clinical manifestations and variety of underlying etiological mechanisms, transtheoretical, patient-oriented and multimodal approach to the therapy of CSBD is recommended.

Diagnosing and treating patients presenting with CSBD should require an expertise in sexual medicine or clinical sexology, and often an interdisciplinary consultation.

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