

Case Report

Exploring Psychiatric Heterogeneity in Compulsive Sexual Behaviour Disorder

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Abstract

Compulsive Sexual Behaviour Disorder (CSBD), newly recognized in ICD-11, is characterized by a persistent inability to control intense sexual impulses, leading to repetitive behaviours that cause significant distress or impairment. Previously misclassified as “sex addiction,” CSBD is now understood as an impulse-control disorder, with emerging evidence challenging addiction-based models and emphasizing emotional dysregulation and psychiatric comorbidities as key factors. Such factors play a pivotal role in informing our assessment and tailoring the therapeutic approach. This case series presents three adult males diagnosed with Compulsive Sexual Behavior Disorder (CSBD), each exhibiting distinct clinical profiles and comorbidities. Case 1 involved a 45-year-old with coronary artery disease, seizure disorder, and a history suggestive of conduct disorder, who presented with hypersexuality and moderate depressive symptoms; remission was achieved with sertraline (150 mg) over 14 weeks. Case 2 described a 25-year-old factory worker experiencing distress due to escalating sexual urges post-marriage; he responded well to fluoxetine (60 mg) and six sessions of cognitive behavioral therapy within 8 weeks. Case 3 featured a 55-year-old with schizophrenia and longstanding paraphilic interests, who achieved remission following inpatient treatment with long-acting antipsychotics and fluoxetine (60 mg) over 18 weeks. These cases highlight CSBD’s diverse manifestations and underscore the importance of nuanced diagnosis and individualized treatment with a significant role for the medication class SSRIs. Recognizing CSBD as distinct from addiction reshapes clinical perspectives and informs more effective interventions.

Keywords

Compulsive Sexual Behaviour Disorder, ICD-11, SSRIs, CBT, Impulse-control, Psychiatric Comorbidity, Schizophrenia, Depression

1. Introduction

For many years, compulsive sexual behaviours were inaccurately framed as a part of ‘sex addiction’, a term which is denied clinical recognition by psychiatrist community [1]. This changed in 2018 when the ICD-11 officially recognized compulsive sexual behaviour disorder (CSBD) as a diagnosable condition, establishing clear diagnostic criteria [2].

Various models have pointed out that compulsive sexual

behaviour as a coping strategy to deal with negative mood states [3-5]. While some models suggest sexual behaviour may temporarily alleviate negative affect, recent research shows mixed findings. In some cases, negative mood may actually reduce craving for sexual stimuli, challenging the addiction framework [6-9].

This case series offers a valuable opportunity to explore the

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clinical variability of compulsive sexual behaviours. A key diagnostic challenge lies in distinguishing pathological patterns from normative sexual expression. We present three distinct cases of compulsive sexual behaviour, each emerging within the context of co-occurring psychiatric conditions.

2. Case Description

Case 1: A 45 years old male with coronary artery disease, hypertension, seizure disorder, hypothyroidism, and alcohol dependence, presented with hypersexuality since the age of 25. He reported excessive masturbation and intrusive urges to have sex with any woman he saw. His 40-year-old wife complained he demanded intercourse more than five times daily; if she refused, he would assault her and force himself on her or watch pornography to masturbate. His childhood was marked by parental loss and neglect. He got involved in frequent fights, showed cruelty to people and animals and had destroyed property, all of which were suggestive of an adolescent onset conduct disorder.

On evaluation, he was also found to have low mood, anhedonia, passive suicidal ideations, and sleep disturbances for past one month, a diagnosis of CSBD with moderate depression was considered. The Hamilton depression scale score was 16. His blood reports and CT brain was normal. Tab. Sertraline was treated with 50 mg and increased to 150 mg over 2 weeks, led to full remission within 14 weeks.

Case 2: A 25-year-old male, married, with no known comorbidities, working in a leather factory, presented with complaints of distress associated with hypersexuality. At around 15 years of age he felt an excessive attraction to girls with recurrent thoughts of wanting to touch them. Around 18 years of age he had multiple sexual partners. His hypersexuality later prompted him to have intercourse with transgender sex workers, who were more energetic and met his expectations, for 2 years. Distress arose after marriage as realised that his sexual demands couldn't be met by his wife alone.

He was managed on with Cap. Fluoxetine, 20 mg initially, later increased to 60 mg, along with around 6 sessions of CBT. All blood reports and CT brain were normal. Within 8 weeks he achieved complete remission.

Case 3: A 55-year-old male patient was brought to psychiatry outpatient-department (OPD) by his wife with complaints of increased sexual attraction to fat elder females for 29 years and hearing voices when alone and suspiciousness that someone is trying to hurt him for 10 years. The onset of hypersexual behaviour was reported at age 16, characterized by recurrent weekend visits to sex workers. This pattern of behaviour was associated with considerable psychological distress, primarily due to the financial strain and the excessive time invested in seeking individuals with a specific body type.

After marriage, at the age of 20, he had to shift his work place to a distant area. Even then his sexual impulses made him seek out other women to have intercourse with. At the age of 45 he started hearing voices which others

cannot hear and suspiciousness towards others. He was diagnosed as having schizophrenia and CSBD and was started on anti-psychotics and Cap. Fluoxetine 40 mg on OPD basis but he failed to take medications regularly because of his psychotic symptoms and poor insight. Later he was admitted in ward and was given long-acting anti-psychotic injections and Cap. Fluoxetine 60 mg. He improved on it and achieved remission with his psychotic symptoms, sexual impulses and thoughts resolved within 18 weeks.

3. Discussion

Compulsive Sexual Behaviour Disorder (CSBD) is not a disorder resembling addiction, despite several arguments and concerns [10].

It is characterized by an inability to control intense sexual impulses, leading to repetitive behaviours that cause personal distress or functional impairment.

A study done in United States of America shows a prevalence of 8.6% for distress and impairment associated with difficulty controlling sexual feelings, urges, and behaviours [11], a systematic review on CSBD reported prevalence rates of 4.2-7% in men and 0-5.5% in women [12].

The fact that it is so common and that it seriously strains relationships makes it more worrisome [13, 14]. It's inclusion in ICD 11 classification offers us a fresh and clear view about the diagnosis itself [15].

In all the above 3 cases the underlying impulsive disorder proved to be the same psychopathology which got corrected with medications of the class Selective serotonin reuptake inhibitors (SSRI) and Cognitive behavioural therapy (CBT).

There is little existing knowledge about the treatment of CSBD but the usual practices involve assessing the severity and planning for CBT, which is considered the first line treatment, and if needed SSRIs are used [16]. We noted that one of our patients who had received CBT along with SSRI had a faster remission when compared to others.

SSRIs were earlier used in CSBD because of its sexual side effects but now it has been found to decrease obsessional thoughts and urges. Most of us chose SSRI medications in CSBD based on the existing psychiatric comorbidities. Psychotherapy proved crucial for rapport, history gathering, and diagnosis accuracy given the nature of the disease.

Role of Cognitive behaviour therapy and its effectiveness in causing early remission is to be noted, this is in accordance with a systematic review on the topic done [17].

4. Conclusions

Compulsive Sexual Behaviour Disorder (CSBD), now clearly defined in ICD-11, reflects a distinct impulse-control pathology rather than an addiction. Its high prevalence and relational impact underscore the need for structured clinical

approaches. Cognitive Behavioural Therapy (CBT) emerges as the cornerstone of treatment, offering early remission and sustained symptom relief. SSRIs, once used for their sexual side effects, now play a targeted role in reducing obsessional urges, especially when psychiatric comorbidities are present.

Abbreviations

ICD	International Classification of Diseases
CSBD	Compulsive Sexual Behaviour Disorder
CT	Computerized Tomography
OPD	Out-patient Department

Author Contributions

Murugavel Veeramani: Conceptualization, Writing - original Draft

Farsana Banu: Supervision, Writing - review and editing

Akshay Ajith: Writing - review and editing

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Data Availability Statement

Not applicable.

Conflicts of Interest

We hereby declare that we have no conflicts of interest with relation to this research paper.

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Biography



Murugavel Veeramani, MBBS, DPM, DNB (Psychiatry), is a dedicated psychiatrist with over eleven years of clinical experience. Currently, he serves as an Assistant professor in the Department of Psychiatry at ESIC Medical College and Hospital, KK Nagar, Chennai. He completed his MBBS from Chengalpattu Government Medical College, followed by a Diploma in Psychological Medicine (DPM) from the Institute of Mental Health, Madras Medical College. He further specialized with a DNB in Psychiatry at the Schizophrenia Research Foundation (SCARF), Chennai. He has worked across general hospital and rehabilitation settings, with a special focus on de-addiction psychiatry and geriatric mental health. His therapeutic expertise includes cognitive behavioural therapy, motivational enhancement therapy and neuromodulation techniques like ECT and tDCS. He has contributed to academic forums through presentations and publications, and actively engages in psychiatric education.



Farsana Banu is a dedicated psychiatrist currently serving as a Senior Resident at ESIC Medical College, Chennai. A gold medalist in MD Psychiatry from JIPMER, Puducherry, she has demonstrated excellence in both clinical practice and academic pursuits. Her medical journey began with an MBBS from Kerala University of Health Sciences, followed by specialized training in diverse psychiatric domains including peripartum psychiatry, deaddiction, psychosexual health, Neuropsychiatrist and child and adolescent psychiatry. She had actively contributed to research, with studies exploring psychotic symptoms and cognitive impairment, as well as the link between sunshine hours and suicide rates. She has participated in numerous national and international CMEs and webinars, reflecting

her commitment to continuous learning. Passionate about teaching, she has mentored MBBS and PG students in both theory and clinical settings.



Akshay Ajith, MBBS, is currently pursuing his MD in Psychiatry as a first-year resident at ESIC Medical College and Hospital, Chennai. He completed his MBBS from Government Medical College, Thiruvananthapuram, where he developed a strong interest in Psychiatry and excelled in multiple quiz competitions in Psychiatry and other medical subjects. After graduation, he gained valuable clinical experience working as a Medical Officer in private clinics and hospitals. Now, eight months into his postgraduate training, he has actively contributed to academic activities by conducting Psychiatry quizzes for undergraduates and engaging in research and conference presentations. He has also been recognized with Best Poster Awards at medical conferences as a first-year resident. As part

of his residency duties, Dr. Akshay is involved in the management of Psychiatry and De-addiction wards, and regularly assists in administering Electroconvulsive Therapy (ECT) under the supervision of his professors. Through these experiences, he continues to develop his clinical acumen and commitment to becoming a compassionate and skilled psychiatrist.

Research Fields

Murugavel Veeramani: De-addiction psychiatry, Dementia, Consultation liaison psychiatry, Psychopharmacology, Neuropsychiatry, non-invasive brain stimulation.

Farsana Banu: Perinatal mental health, De-addiction psychiatry, Child psychiatry, Consultation liaison psychiatry, neuropsychiatry

Akshay Ajith: De-addiction psychiatry, Consultation liaison psychiatry, Psychopharmacology, Neuropsychiatry, schizophrenia