Compulsive sexual behaviour disorder in the ICD-11

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to support it. However, these factors must be considered when deciding what is immediately implementable, versus that which requires a supportive framework which has yet to be created.

All digital health research and claims are informative. Some offer immediate solutions to health care that should be implemented today and others highlight the potential of what may be possible. However, blurring the line between actual and aspirational can be counterproductive. Claiming that aspirational digital health research is ready for immediate use can lead to immediate negative results and broad disappointment. It may even inadvertently contribute to digital health "hype" and foster undue skepticism for the field.

However, ignoring digital health technologies with good evidence for real-world implementation is a missed opportunity for improving patient outcomes. Appreciating how aspirational research can guide, inform, and inspire current efforts is also important. Likewise, appreciating the real world success of actualized efforts can help guide aspirational research to be more translatable into health care systems.

There is no superior designation, as both ends of the actual and aspirational spectrum have critical roles that cannot be separated. However, the value of both depends upon correct identification of where any given project lies on this spectrum – and further consideration of populations sampled and incentives used are critical to determining this.

John Torous[1], Joseph Firth[2]
[1]Department of Psychiatry and Division of Clinical Informatics, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA, USA; [2]NICM, School of Science and Health, Western Sydney University, Sydney, Australia

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Compulsive sexual behaviour disorder in the ICD-11

During the last decade, there has been heated debate regarding whether compulsive sexual behaviour should be classified as a mental/behavioural disorder. Compulsive sexual behaviour disorder has been proposed for inclusion as an impulse control disorder in the ICD-11[1]. It is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges, resulting in repetitive sexual behaviour over an extended period (e.g., six months or more) that causes marked distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

The pattern is manifested in one or more of the following: a) engaging in repetitive sexual activities has become a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities; b) the person has made numerous unsuccessful efforts to control or significantly reduce repetitive sexual behaviour; c) the person continues to engage in repetitive sexual behaviour despite adverse consequences (e.g., repeated relationship disruption, occupational consequences, negative impact on health); or d) the person continues to engage in repetitive sexual behaviour even when he/she derives little or no satisfaction from it.

Concerns about overpathologizing sexual behaviours are explicitly addressed in the diagnostic guidelines proposed for the disorder. Individuals with high levels of sexual interest and behaviour (e.g., due to a high sex drive) who do not exhibit impaired control over their sexual behaviour and significant distress or impairment in functioning should not be diagnosed with compulsive sexual behaviour disorder. The diagnosis should also not be assigned to describe high levels of sexual interest and behaviour (e.g., masturbation) that are common among adolescents, even when this is associated with distress.

The proposed diagnostic guidelines also emphasize that compulsive sexual behaviour disorder should not be diagnosed based on psychological distress related to moral judgments or disapproval about sexual impulses, urges or behaviours that would otherwise not be considered indicative of psychopathology. Sexual behaviours that are egodystonic can cause psychological distress; however, psychological distress due to sexual behaviour by itself does not warrant a diagnosis of compulsive sexual behaviour disorder.

Careful attention must be paid to the evaluation of individuals who self-identify as having the disorder (e.g., calling themselves "sex addicts" or "porn addicts"). Upon examination, such individuals may not actually exhibit the clinical characteristics of the disorder, although they might still be treated for other mental health problems (e.g., anxiety, depression). Additionally, individuals often experience feelings such as shame and guilt in relationship to their sexual behaviour[2], but these experiences are not reliably indicative of an underlying disorder.

The proposed diagnostic guidelines also assist the clinician in differentiating compulsive sexual behaviour disorder from other mental disorders and other health conditions. For example, although bipolar disorder has been found at elevated rates among individuals with compulsive sexual behaviour disorder[3], sexual behaviours must be persistent and occur independently of hypomanic or manic episodes to provide a basis for a possible diagnosis of the disorder. A diagnosis of compulsive sexual behaviour disorder should not be made when the behaviour can be explained by other medical conditions (e.g., dementia) or by the effects of certain medications prescribed to treat specific medical conditions (e.g., Parkinson's disease)[4] or is entirely attributable to the direct effects of illicit substances

on the central nervous system (e.g., cocaine, crystal methamphetamine).

Currently, there is an active scientific discussion about whether compulsive sexual behaviour disorder can constitute the manifestation of a behavioural addiction[5]. For ICD-11, a relatively conservative position has been recommended, recognizing that we do not yet have definitive information on whether the processes involved in the development and maintenance of the disorder are equivalent to those observed in substance use disorders, gambling and gaming[6]. For this reason, compulsive sexual behaviour disorder is not included in the ICD-11 grouping of disorders due to substance use and addictive behaviours, but rather in that of impulse control disorders. The understanding of compulsive sexual behaviour disorder will evolve as research elucidates the phenomenology and neurobiological underpinnings of the condition[7].

In the absence of consistent definitions and community-based epidemiological data, determining accurate prevalence rates of compulsive sexual behaviour disorder has been difficult. Epidemiological estimates have ranged up to 3-6% in adults[8], though recent studies have produced somewhat lower estimates of 1 to 3%[9]. The more restrictive diagnostic requirements proposed for ICD-11 would be expected to produce lower prevalence rates.

In general, men exhibit the disorder more frequently than women, although robust data examining gender differences are lacking. Additionally, higher rates of the disorder have been noted among individuals with substance use disorders. Among treatment seekers, the disorder negatively impacts occupational, relationship, physical health and mental health functioning. However, systematic data are lacking regarding the prevalence of the disorder across different populations and associated socio-cultural and socio-demographic factors, including among non-treatment seekers.

Growing evidence suggests that compulsive sexual behaviour disorder is an important clinical problem with potentially serious consequences if left untreated. We believe that including the disorder in the ICD-11 will improve the consistency with which health professionals approach the diagnosis and treatment of persons with this condition, including consistency regarding when a disorder should not be diagnosed. Legitimate concerns about overpathologizing sexual behaviours have been carefully addressed in the proposed diagnostic guidelines. We posit that inclusion of this category in the ICD-11 will provide a better tool for addressing the unmet clinical needs of treatment seeking patients as well as possibly reduce shame and guilt associated with help seeking among distressed individuals.

The proposed diagnostic guidelines will be tested in international multilingual Internet-based field studies using standardized case material, which will help to assess the generalizability of the construct across different regions and cultures, and clinicians' ability to distinguish it from normal variations in sexual behaviour and from other disorders. Additional field studies in clinical settings will provide further information about the clinical utility of the proposed diagnostic guidelines for the disorder among clinical populations.

Shane W. Kraus[1], Richard B. Krueger[2], Peer Briken[3], Michael B. First[2], Dan J. Stein[4], Meg S. Kaplan[2], Valerie Voon[5], Carmita H.N. Abdo[6], Jon E. Grant[7], Elham Atalla[8], Geoffrey M. Reed[9,10]

[1]Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA, USA; [2]Department of Psychiatry, Columbia University, College of Physicians and Surgeons and New York State Psychiatric Institute, New York, NY, USA; [3]Institute for Sex Research and Forensic Psychiatry, University Medical Center Hamburg-Eppendorf, Hamburg, Germany; [4]Department of Psychiatry, University of Cape Town and Groote Schuur Hospital, Cape Town, South Africa; [5]Department of Psychiatry, University of Cambridge, Cambridge, UK; [6]Department of Psychiatry, Faculty of Medicine, University of São Paulo, São Paulo, Brazil; [7]Department of Psychiatry and Behavioral Neuroscience, University of Chicago, Chicago, IL, USA; [8]Primary Care and Public Health Directorate, Ministry of Health, Manama, Bahrain; [9]Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland; [10]Global Mental Health Program, Columbia University Medical Center, New York, NY, USA

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Decline in suicide mortality after psychiatric hospitalization for depression in Finland between 1991 and 2014

Depression is the most important mental disorder in terms of suicide mortality. Numerous studies over time have estimated the lifetime risk of suicide in depression, including a recent Danish national study[1]. Organization of services and treatment practices for depression have undergone major changes over the past decades, including remarkable growth in the use of antidepressants, emphasis on community-based services, and deinstitutionalization. Temporal trends in suicide mortality among psychiatric patients with depression can be expected, but have not been investigated.

We followed a Finnish population-based cohort of depressive patients (N=56,826), with a first lifetime hospitalization due to depression between 1991 and 2011, up to the end of the year 2014 (maximum follow-up: 24 years). Here we report both cumulative risk of suicide and temporal trends in suicide mortality.