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Research Article

Understanding Hypersexuality: Diagnosis And Treatment Approaches

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ABSTRACT

Despite the fact that many individuals with sexual addiction, also known as hypersexual disorder, have serious psychological problems, psychiatrists have largely ignored this condition. There is a lack of scientific data on sexual addiction since it is not covered by any edition of the Diagnostic and Statistical Manual of Mental Disorders. However, people who were categorized as having a compulsive, impulsive, addictive, or hypersexual disorder reported experiencing sexual fantasies along with obsessive thoughts and behaviours. The prevalence of disorders associated with sexual addiction currently ranges from 3% to 6%. A range of detrimental habits, such as excessive masturbation, cybersex, pornography, sexual activity with consenting adults, telephone sex, and visits to strip clubs, are collectively referred to as "sexual addiction/hypersexual disorder." The detrimental consequences of sexual addiction are similar to those of other addictive disorders. Addictive, mental, and physical disorders coexist with sexual addiction. Research on sexual addiction has increased dramatically in recent years, and screening tools for sexual addiction disorders have become more and more sophisticated. Sexual addiction should be treated with a combination of psychological and pharmaceutical methods, just like other behavioural addictions. The therapy method should incorporate the physical and psychiatric co-morbidities that are often associated with sexual addiction. Additionally, group-based therapy ought to be tried.

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INTRODUCTION

Hypersexual Disorder, also known as compulsive sexual behaviour, is a condition characterized by an overwhelming and persistent preoccupation with sexual thoughts, fantasies, and behaviours[1]. Individuals with this disorder often experience a compulsive urge to engage in sexual activities, despite negative consequences such as personal distress, relationship problems, or social and occupational impairments. The behaviour typically occurs outside of a person's control, leading to significant distress and interference with daily functioning. Although not all diagnosis manuals ,it shares traits with other behavioural addictions[2]. To assist people, control the cravings and related difficulties, treatment may include cognitive-behavioural therapy (CBT) and in certain situations, medication. A thorough approach to treatment is essential since hyper sexuality is frequently associated with underlying mental health conditions including anxiety, depression, or trauma . It has drawn more attention and concern in the domains of sexology, psychiatry, and psychology[3]. Hypersexual condition, which is characterized by a pattern of strong and frequent sexual fantasies, impulses, or actions that substantially disrupt a person's everyday life and general well-being, presents particular difficulties for both those who are afflicted and medical professionals. [4]

The definition and conceptualization of hypersexual disorder, as well as the term's development and current place in diagnostic classifications, will be covered in detail in the first section of this paper. This will lay the groundwork for comprehending the difficulties in recognizing and classifying hypersexual dysfunction as a mental illness.[4]

CONCEPTUALIATION:

The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) disapproved of the addition of hypersexual disorder (HD) as a brand-new, independent diagnosis[5]. Lack of scientific study, insufficient neuropsychological testing, and possible abuse of novel sexual illnesses by overzealous members of the legal community were among the issues brought up about the proposed HD diagnosis[6][7]

To better understand hypersexual behaviour in sexual minorities, such as members of the lesbian, gay, bisexual, trans, and queer communities, research defining group-specific cut off scores on popular HD assessments is required. As of right moment, no research has been done on HD in a trans population. The possible pathologizing of sexual minorities is still a significant and unsolved subject in the HD literature, despite the fact that some study has been done on gay, bisexual, and other men who have sex with men (GBMSM).[5]

Even though the proposed HD diagnosis was rejected, research into how to conceptualize and evaluate HD is still ongoing. Non-paraphilic, uncontrollable fantasies, desires, and behaviours that resulted in negative outcomes and clinically significant impairment in key areas of functioning for at least six months , seven were the suggested criteria for HD[8]. Sexual fantasies, impulses, and actions are commonly used by patients who fit these characteristics as a coping mechanism for anxiety or dysphoric moods. In addition to numerous failed attempts to regulate their sexual fantasies, desires, or activities, patients who fit these criteria will have had negative outcomes. There are few population-based epidemiologic data on hypersexual behaviour, and the great bulk of the research that is currently available only looks at hypersexual activity in men.[8]

ASSESSMENT:

In 2009, the Paraphilias Sub-Group of the DSM-5 Workgroup on Sexual and Gender Identity Disorders proposed that "hypersexual disorder" be added to the DSM-5 as a distinct category with diagnostic criteria.

However, the inclusion of hypersexual disorder as a separate subgroup of sexual and gender identity disorders was rejected by the DSM-5. Reid (2014) listed the following as the reasons: [9]

- A lack of scientific study, inadequate neuropsychological testing, and potential misuse of recently acquired sexual disorder diagnoses by the legal system, particularly in forensic settings where hypersexual criminal defendants accused of child abuse may utilize the disorder as a defence.
- Hypersexual disorder may be a symptom of another mental condition, even though it is not a genuine diagnosis.[10] Therefore, the DSM-5 lacks diagnostic criteria.

DSM-5 PARAPHILIAS SUB WORKGROUP'S SUGGESTED DIAGNOSTIC CRITERIA FOR HYPERSEXUAL DISORDER :

A. Frequent and intense sexual fantasies, impulses, or behaviours linked to three or more of the following five criteria over a minimum of six months:

1. Sexual thoughts, cravings, or behaviours often take precedence over other important (non-sexual) goals, pursuits, and obligations.
2. Frequently experiencing sexual fantasies, desires, or behaviours in response to dysphoric mood states, such as melancholy, boredom, annoyance, or worry.
3. Frequently experiencing sexual desires, fantasies, or actions in response to stressful life circumstances.
4. Frequent but unsuccessful attempts to control or slightly reduce these fantasies, behaviours, or sexual cravings.
5. Engaging in sexual behaviour repeatedly while ignoring the possibility of harming oneself or others physically or psychologically. [11]

B. Clinically significant personal discomfort or impairment in social, occupational, or other crucial domains of functioning is associated with the frequency and severity of these sexual fantasies, wants, or behaviours.

C. These sexual fancies, impulses, or behaviours are not brought on by the direct physiological effects of an external substance, such as an illegal drug or medication. Indicate if: [12]

- Masturbating
- Engaging in sexual activities with consenting adults
- Internet sex
- Sex clubs over the phone

In ICD-11 (expected to go into effect in January 2022) The term "compulsive sexual behaviour disorder" refers to hyper sexuality, which is described as follows

The defining feature of compulsive sexual behavior disorder is the inability to manage strong, recurring sexual urges or impulses, leading to repetitive sexual actions. Some symptoms involve repeated unsuccessful efforts to significantly cut back on repetitive sexual behaviors, ongoing engagement in such behaviors, and sexual activities dominating a person's life to the extent that they neglect personal hygiene, health, and other interests, responsibilities, or activities even when these actions lead to negative consequences or bring little to no satisfaction. [12]. An inability to control strong sexual urges or urges, resulting in a pattern of repeated sexual behaviour that occurs over an

extended period of time (e.g., over 6 months) and causes significant distress or impairment in important areas of functioning, such as personal, family, social, educational, or occupational functioning. This need is not satisfied by suffering associated solely with withdrawal from moral judgments, sexual desires, urges, and actions.

hyper sexuality causes stress, people who exhibit it may also experience anxiety and sadness at the same time. Kalra (2013) describes a case of a sad guy who exhibits obsessive sexual behaviour, namely compulsive frottage. According to Mina (2019), a depressed woman exhibited a strong sexual behaviour, want to inappropriately touch the men, even when family members were there. [11][12]

It is important to understand the underlying disease before treating hyper sexuality. It is therefore crucial to exclude misuse of alcohol and drugs (such as cocaine, amphetamines, hallucinogenic, and propofol anaesthetics) and dopamine agonists for the treatment of prolactinomas, Parkinsonism, and restless legs syndrome. It's also important to rule out mania and hypergadism .[11][13]

ETIOLOGY :

Like many mental health disorders, hypersexual illness is most likely caused by a confluence of biological, psychological, and sociocultural variables. In comparison to other mental health illnesses, research on hypersexual dysfunction is still somewhat restricted.[14]

The causes of hypersexual disorder are intricate and probably stem from a mix of factors, such as neurobiological imbalances (especially issues with dopamine regulation), genetic tendencies, psychological elements like trauma or coping strategies, and possible environmental factors. Significant brain regions, including the prefrontal cortex, amygdala, and striatum, are crucial in controlling sexual behaviour and may lead to hypersexual behaviours when their functioning is impaired.[14]

CO- MORBIDITY AND CO-OCCURING CONDITIONS :

When a person has several medical or mental health conditions, it's referred to as co-morbidity. It is common for people with hypersexual disorder to have other conditions that could influence the development, expression, or results of hypersexual behaviour [15]. In order to provide comprehensive and successful therapy, it is critical to identify and manage these additional conditions. The following are a few co-morbidities and concurrent conditions that are commonly linked to hypersexual disorder

- Mood disorder
- Anxiety disorder
- Substance use disorder
- Personality disorder
- Impulse control disorder
- Childhood trauma and posttraumatic stress disorder
- Body image and eating disorder
- Other sexual disorder

Psychotherapy, medication, support groups, and specialized therapies for particular co-occurring illnesses can all be used in treatment techniques.[15] [16]

IMPACTS ON PHYSICAL AND MENTAL HEALTH:

IMPACTS ON MENTAL HEALTH: [17]

EMOTIONAL DISTRESS:

Feelings of shame, guilt, and self-loathing can result from obsessive sexual behaviour. Because they are unable to manage their behaviour and

struggle to control their sexual cravings, people with hypersexual condition may suffer from mental discomfort.[17]

DEPRESSION AND ANXIETY:

Because of the detrimental emotional effects of their actions, hypersexual may be more likely to experience anxiety and sadness. Because people may use sex as a coping strategy, these mental health issues may worsen the cycle of hypersexual behaviours.[17]

RELATIONSHIPISSUES:

Intimate relationships may be strained by hypersexual behaviours. Conflicts and instability in the relationship might result from partners feeling deceived, wounded, or emotionally cut off.[17]

STIGMA ANAD ISOLATION:

Because hypersexual behaviours are stigmatized, those who are affected may retreat from social situations and isolate themselves in order to escape criticism and unfavourable responses from others.[17]

SELF-ESTEEM IMPAIRED:

Chronic compulsive
sexual behaviour can damage a person's self-esteem and self-worth, leading to feelings of inadequacy and self-doubt.[17]

COGNITIONAL DISTORTIONS:

Individuals with hypersexual disorder may experience cognitive distortions, including minimizing the adverse effects of their behaviour or rationalizing their choices, to support the continuation of hypersexual activities.[17]

IMPACTS ON PHYSICAL HEALTH:

RISKY SEXUAL PRACTICES:

People who are hypersexual may participate in risky sexual behaviours, such as having several sexual partners and unprotected sex, which raises the risk of STIs and unwanted pregnancies.[18]

EXHAUSTION ON PHYSICAL LEVEL:

Physical weariness and exhaustion brought on by excessive sexual activity can have an adverse effect on general health and wellbeing.[18]

SLEEP INTERRUPTIONS:

Sleep disruptions and deprivation may result from hypersexual behaviours that disrupt regular sleep cycles.[18]

SUBSTANCE ABUSE AND USE:

Substance misuse issues may result from some people with hypersexual disorder using drugs or alcohol as a coping mechanism for the mental discomfort brought on by their behaviours.[18]

PHYSIAL INJURIES:

Risky sexual behaviour can lead to physical harm like abrasions or bruises.[18]

PERSONAL HEALTH NEGLECT:

Sexual activity obsession can result in disregard for one's health and personal cleanliness, which can negatively impact one's general physical well-being.[18]

TREATMENT :

A variety of therapeutic modalities, including group therapy, psychodynamic therapy, cognitive behavioural therapy (CBT), and occasionally medication, are used to treat hypersexual dysfunction. Helping people take charge of their sexual practices, addressing underlying psychological issues, and enhancing general functioning and well-being are the objectives of treatment. It is crucial to remember that people who are worried about their sexual conduct should consult qualified mental health specialists who

have treated cases of compulsive or hypersexual activity.[19]

Drugs used to treat hyper sexuality include

- antidepressants,
- anti-androgens, and
- mood stabilizers.

ANTIDEPRESSANTS :

Selective serotonin reuptake inhibitors (SSRIs): May help with compulsive sexual behaviour

Fluoxetine: An SSRI that can improve mood, sleep, and energy

Paroxetine: An SSRI that may help with hypersexual behaviour

Citalopram: An SSRI that may help with inappropriate sexual behaviour

TRICYCLIC ANTI DEPRESSANT :

May help with hypersexual behaviour

Clomipramine: A tricyclic antidepressant that may help with hypersexual behaviour

Trazodone: An antidepressant that may help with hypersexual behaviour

ANTI ANDROGENS :

Cyproterone acetate: An anti-androgen that reduces testosterone levels

Mood stabilizers May help reduce compulsive sexual urges.

OTHER DRUGS :

Naltrexone: May help with compulsive sexual behaviour by blocking the brain's pleasure response

Leuprolide acetate: May help with hypersexual behaviour or paraphilias

Triptorelin: A gonadotropin-releasing hormone (GnRH) analogue that inhibits testosterone production

Psychotherapy may also be used to treat hyper sexuality.

COMPLICATIONS :

Significant relationship strain, harm to one's personal and professional life from an excessive focus on sex, an elevated risk of STDs, financial hardships from the expense of sex services, mental health conditions like anxiety and depression, feelings of guilt and shame, and possible legal ramifications from engaging in risky sexual behaviours are just a few of the complications that can arise from hyper sexuality.

IMPORTANT ISSUE WITH HYPERSEXUALITY :

RELATIONSHIP ISSUE :

Relationships that have been harmed by infidelity, secrecy, or disregard for one another's needs. Workplace problems include decreased output, losing one's job as a result of excessive sexual activity, or acting inappropriately at work.

WORK ISSUE :

Workplace problems include decreased output, losing one's job as a result of excessive sexual activity, or acting inappropriately at work.

FINANCIAL ISSUE :

Expending a lot of money on sex workers, pornography, or other sexual services. Legal concerns: Depending on the type of behaviour, there may be arrests for sexual offenses.

MENTAL HEALTH ISSUE :

Mental health issues include emotions of guilt and shame, worry, depression, and low self-esteem.

ETHICAL CONSIDERATION :

When diagnosing, treating, and evaluating hypersexual illness, cultural and ethical factors are crucial. It is important to thoroughly investigate the ethical issues surrounding diagnosis and treatment as well as the cultural context in which hypersexual behaviour is understood [20].Among the crucial ethical and cultural factors are .

CULTURAL VALUE AND NORMS :

varied countries have very varied cultural norms about sexuality and sexual conduct. While certain cultures may be more strict or repressive, others may be more accepting of sexual expression. When diagnosing and treating patients with hypersexual diseases, clinicians need to be attentive to cultural differences and refrain from enforcing their own cultural norms.[20]

SHAME AND STIGMA :

Talking about sexual conduct or getting therapy for sexual problems can be quite stigmatized in some cultures. The stigma attached to hypersexual conduct may keep people from talking to medical experts about their issues or seeking therapy[20]. The diagnosis of hypersexual disorder presents ethical challenges because major classification systems such as the DSM-5 lack consistent diagnostic criteria for the illness. Clinicians must carefully assess whether hypersexual behaviours are present and how they affect a person's life while taking co morbidities or underlying problems into account.[21]

INFORMED CONSENT :

Getting the patient's informed permission is essential while treating hypersexual condition. This entails describing the course of therapy, outlining any possible dangers and advantages, and honouring the patient's autonomy to choose their own medical care. Privacy and confidentiality: Preserving privacy and confidentiality is crucial since hypersexual activities are delicate[20]. Clinicians should make sure that any information discussed during evaluations and treatment stays private and is only released with the patient's permission or as mandated by law.

INVOLVEMENT OF PARTNERS AND FAMILY :

Rebuilding trust and addressing relationship problems may require involving partners or family members in the therapeutic process. However, before including others in treatment, professionals must respect the patient's autonomy and obtain agreement. Steer clear of pathologization.[21]

FUTURISTIC CONSIDERATION :

Future research and therapy of hypersexual dysfunction will focus on a number of important areas that can further our knowledge of this intricate illness and advance therapeutic modalities.[22][23]

AMONG THE POSSIBLE FUTURE PATHS ARE STANDARDIZATION OF DIASNOSTIC CRITERIA :

Further research is needed to establish accurate and consistent diagnostic criteria for hypersexual disorder in major classification systems like the DSM and ICD.
This would simplify the accurate diagnosis of patients and consistently identify those affected. [22]

PREVALENCE AND EPIDEMIOLOGICAL STUDIES :

By carrying out extensive prevalence and epidemiological studies, it will be possible to ascertain the worldwide prevalence of hypersexual dysfunction and its effects on various communities, providing insight into the condition's potential public health ramifications.[22]

DEVELOPMENT OF EVIDENCE – BASED THERAPIES :

It is crucial to develop and assess evidence-based therapies that are especially suited to hypersexual diseases. The efficacy of various therapeutic approaches, such as group treatments, psychodynamic therapy, and cognitive-behavioural therapy, should be investigated in research. [23]

CO- OCCURING CONDITIONS :

Additional studies are required to establish the connection between hypersexual disorder and co-existing mental health issues, including mood disorders, anxiety disorders, and substance use disorders. A greater understanding of these connections can facilitate the creation of more extensive treatment plans.[23]

INCLUDING TECHNOLOGY :

Utilizing technology, such as virtual therapy platforms and smart phone applications, may improve treatment accessibility and participation for people with hypersexual disorders. Resolving trauma experienced as a child:

Targeted prevention and intervention initiatives can result from examining the part early adverse experiences and childhood trauma play in the development of hypersexual behaviours.[22][23]

RISK FCTORS :

NEUROBIOLOGICAL FACTORS :

Hypersexual dysfunction may arise as a result of specific neurobiological causes. According to research, the dysregulation of sexual behaviours may be caused by changes in brain areas such the striatum, amygdala, and prefrontal cortex that are involved in reward processing and impulse control.[24]

GENETICS:

The propensity for hypersexual activities may also be influenced by genetic factors. According to studies, people who have a family history of addiction or impulse control issues may be more susceptible to hypersexual condition.[24]

ADVERSITY THROUGHOUT THE CHILDHOOD :

Adversity during childhood, such as physical or sexual abuse, neglect, or other types of trauma, has been associated with the development of hypersexual tendencies in later life. Emotional dysregulation and coping mechanisms involving sexual activities may be influenced by these experiences[24].

CONCLUSION :

Hypersexual disorder, commonly referred to as compulsive sexual behavior, is marked by an intense and ongoing preoccupation with sexual ideas, fantasies, and actions. Co-occurring conditions and co-morbidities that are often linked with hypersexual disorder comprise mood disorders, anxiety disorders, substance use disorders, personality disorders, impulse control disorders, childhood trauma, post-traumatic stress disorder, body image and eating disorders, along with other sexual disorders. Individuals with hypersexual dysfunction generate challenging

situations for themselves and others nearby. This illness can affect their dignity, work life, mental health problems such as anxiety and depression, feelings of guilt and shame, a higher risk of sexually transmitted infections, and financial struggles resulting from the expenses of sex services. To raise awareness of sexual matters and provide counselling therapies, we are initiating sex education programs for students' schools and their parents. We also develop an awareness program to enhance understanding of sexual diseases. Pharmacological approaches for hypersexual dysfunction involve cognitive behavioural therapy (CBT), psychodynamic therapy, and occasionally medication. Moreover, drugs prescribed for hypersexuality disorder consist of antidepressants, selective serotonin reuptake inhibitors (such as fluoxetine), and anti-androgens. We are able to identify people with hypersexual disorders and start giving them medication and counselling because to these awareness initiatives. The medication can start a healthy life and manage intense sexual desire.

REFERENCES

1. Tiwari S, Kaur D. A concept of hypersexual disorder. Res J Pharm Biol Chem Sci. 2017;8(2):1346-1349.
2. Goodman A. Addiction: definition and implications. Br J Addict. 1990;85(11):1403-1408.
3. Kalichman SC, Rompa D. Sexual sensation seeking and sexual compulsivity scales: reliability, validity, and predicting HIV risk behavior. J Pers Assess. 1995;65(3):586-601. doi:10.1207/s15327752jpa6503_16.
4. World Health Organization. International classification of diseases, 10th revision (ICD-10). Geneva: World Health Organization; 1992.
5. Bancroft J, Janssen E. The dual control model of male sexual response: a theoretical approach to centrally mediated erectile dysfunction. Neurosci Biobehav Rev. 2000;24(5):571-579.
6. Reid RC, Carpenter BN, Hook JN, Garos S, Manning JC, Gilliland R, et al. Report of findings in a DSM-5 field trial for hypersexual disorder. J Sex Med. 2012;9(11):2868-2877.
7. Gold SN, Heffner CL. Sexual addiction: many conceptions, minimal data. Clin Psychol Rev. 1998;18(3):367-381.
8. Halperin AL. [Complete bibliographic details required].
9. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): American Psychiatric Publishing; 2013.
10. Halpern AL. The proposed diagnosis of hypersexual disorder for inclusion in DSM-5: unnecessary and harmful. Arch Sex Behav. 2011;40:487-488.
11. Thibaut F. Incorporating pharmacological treatment strategies. In: Birchard T, Benfield J, editors. Routledge international handbook of sexual addiction. London: Routledge; 2018. p.282-292.
12. Twohig MP, Crosby JM. Acceptance and commitment therapy as a treatment for problematic internet pornography viewing. Behav Ther. 2010;41(3):285-295.
13. Verholleman A, Victorri-Vigneau C, Laforgue E, et al. Naltrexone use in treating hypersexuality induced by dopamine replacement therapy: impact of OPRM1 A/G polymorphism on its effectiveness. Int J Mol Sci. 2020;21(9):3002. doi:10.3390/ijms21093002.
14. Chamberlain SR, Fineberg NA, Blackwell AD, Robbins TW, Sahakian BJ. Motor inhibition and cognitive flexibility in obsessive-compulsive disorder and trichotillomania. Am

J Psychiatry. 2006;163(7):1282-1284. doi:10.1176/ajp.2006.163.7.1282.
15. Bostwick JM, Bucci JA. Internet sex addiction treated with naltrexone. Mayo Clin Proc. 2008;83(2):226-230. doi:10.4065/83.2.226.
16. DeVito EE, Worhunsky PD, Carroll KM, Rounsaville BJ, Kober H, Potenza MN. A preliminary study of the neural effects of behavioral therapy for substance use disorders. Drug Alcohol Depend. 2012;122(3):228-235. doi:10.1016/j.drugalcdep.2011.10.002.
17. Gilliland R, South M, Carpenter BN, Hardy SA. The roles of shame and guilt in hypersexual behavior. Sex Addict Compulsivity. 2011;18(1):12-29.
18. Kafka MP. Hypersexual disorder: a proposed diagnosis for DSM-V. Arch Sex Behav. 2010;39(2):377-400. doi:10.1007/s10508-009-9574-7.
19. Tiwari S. Addyi—change the women's sexual satisfying event. Res J Pharm Biol Chem Sci. 2017;8(2):2424-2428.
20. Tiwari S. Hypersexual disorder: a comprehensive review of conceptualization, etiology, assessment and treatment. [Publication details incomplete].
21. Kalichman SC, Johnson JR, Adair V, Rompa D, Multhauf K, Kelly JA. Sexual sensation seeking: scale development and predicting AIDS-risk behavior among homosexually active men. J Pers Assess. 1994;62(3):385-397. doi:10.1207/s15327752jpa6203_1.
22. Abell JW, Steenbergh TA, Boivin MJ. Cyberporn use in the context of religiosity. J Psychol Theol. 2006;34(2):165-171.
23. Tiwari S. Hypersexual disorder: a comprehensive review of conceptualization, etiology, assessment and treatment. [Duplicate/incomplete reference; publication details required].
24. Chamberlain SR, Fineberg NA, Blackwell AD, Robbins TW, Sahakian BJ. Motor inhibition and cognitive flexibility in obsessive-compulsive disorder and trichotillomania. Am J Psychiatry. 2006;163(7):1282-1284. doi:10.1176/ajp.2006.163.7.1282.
25. Kraus SW, Voon V, Potenza MN. Should compulsive sexual behavior be considered an addiction? Addiction. 2016;111(12):2097-2106. doi:10.1111/add.13297.
26. Kraus SW, Krueger RB, Briken P, First MB, Stein DJ, Kaplan MS, et al. Compulsive sexual behaviour disorder in the ICD-11. World Psychiatry. 2018;17(1):109-110. doi:10.1002/wps.20499.
27. Montgomery-Graham S. Conceptualization and assessment of hypersexual disorder: a systematic review of the literature. Sex Med Rev. 2017;5(2):146-162. doi:10.1016/j.sxmr.2016.11.001.
28. Derbyshire KL, Grant JE. Compulsive sexual behavior: a review of the literature. J Behav Addict. 2015;4(2):37-43. doi:10.1556/2006.4.2015.003.
29. Briken P. An integrated model to assess and treat compulsive sexual behaviour disorder. Nat Rev Urol. 2020;17(7):391-406. doi:10.1038/s41585-020-0343-7.
30. Fong TW. Understanding and managing compulsive sexual behaviors. Psychiatry (Edgmont). 2006;3(11):51-58.
31. Bancroft J, Janssen E, Strong D, Carnes L, Vukadinovic Z, Long JS. Sexual risk-taking in gay men: the relevance of sexual arousability, mood, and sensation seeking. Arch Sex Behav. 2003;32(6):555-572.
32. Coleman E. Compulsive sexual behavior: new concepts and treatments. J Psychol Hum Sex. 1991;4(2):37-52.
33. Kafka MP, Hennen J. The paraphilia-related disorders: an empirical investigation of nonparaphilic hypersexuality disorders in outpatient males. J Sex Marital Ther.

1999;25(4):305-319. doi:10.1080/00926239908404008.
34. Black DW, Kehrberg LL, Flumerfelt DL, Schlosser SS. Characteristics of 36 subjects reporting compulsive sexual behavior. Am J Psychiatry. 1997;154(2):243-249.
35. Dickenson JA, Gleason N, Coleman E, Miner MH. Prevalence of distress associated with difficulty controlling sexual urges, feelings, and behaviors in the United States. JAMA Netw Open. 2018;1(7).
36. Castro-Calvo J, Ballester-Arnal R, Potenza MN, King DL, Billieux J, Gil-Llario MD. Occurrence and clinical characteristics of compulsive sexual behavior disorder: a cluster analysis in two independent community samples. J Behav Addict. 2020;9(2):446-463.
37. Bőthe B, Potenza MN, Griffiths MD, Kraus SW, Klein V, Fuss J, et al. Compulsive sexual behavior disorder in 42 countries: insights from the International Sex Survey and introduction of standardized assessment tools. J Behav Addict. 2023;12(2):393-407.
38. Klein V, Rettenberger M, Briken P. Self-reported indicators of hypersexuality and its correlates in a female online sample. J Sex Med. 2014;11(8):1974-1981. doi:10.1111/jsm.12602.
39. Långström N, Hanson RK. High rates of sexual behavior in the general population: correlates and predictors. Arch Sex Behav. 2006;35(1):37-52.
40. Seegers JA. The prevalence of sexual addiction symptoms on the college campus. Sex Addict Compulsivity. 2003;10(4):247-258.
41. Fuss J, Briken P, Stein DJ, Lochner C. Compulsive sexual behavior disorder in obsessive-compulsive disorder: prevalence and associated comorbidity. J Behav Addict. 2019;8(2):242-248. doi:10.1556/2006.8.2019.23.
42. Briken P, Habermann N, Berner W, Hill A. Diagnosis and treatment of hypersexuality in men. Dtsch Arztebl Int. 2007;104(45).
43. Reid RC, Garos S, Carpenter BN. Reliability, validity, and psychometric development of the Hypersexual Behavior Inventory in an outpatient sample of men. Sex Addict Compulsivity. 2011;18(1):30-51. doi:10.1080/10720162.2011.555709.
44. Olver ME, Kingston DA, Laverty EK, Seto MC. Psychometric properties of common measures of hypersexuality in an online Canadian sample. J Sex Med. 2022;19(2):331-346. doi:10.1016/j.jsxm.2021.12.002.
45. Ventuneac A, Rendina HJ, Grov C, Mustanski B, Parsons JT. An item response theory analysis of the Sexual Compulsivity Scale and its correspondence with the Hypersexual Disorder Screening Inventory among highly sexually active gay and bisexual men. J Sex Med. 2015;12(2):481-493. doi:10.1111/jsm.12783.
46. Miner MH, Coleman E, Center BA, Ross M, Rosser BRS. The Compulsive Sexual Behavior Inventory: psychometric properties. Arch Sex Behav. 2007;36(4):579-587.
47. McBride KR, Reece M, Sanders SA. Predicting negative sexual health outcomes from problematic sexual behavior. Arch Sex Behav. 2008;37(4):574-583.
48. Kalichman SC, Cain D. The relationship between indicators of sexual compulsivity and high-risk sexual practices among men and women receiving services from a sexually transmitted infection clinic. J Sex Res. 2004;41(3):235-241.
49. Wéry A, Burnay J, Karila L, Billieux J. The Short French Internet Addiction Test adapted to online sexual activities: validation and links with online sexual preferences and addiction symptoms. J Sex Res. 2016;53(5):510-525.

50. Bőthe B, Tóth-Király I, Potenza MN, Griffiths MD, Orosz G, Demetrovics Z. Revisiting the role of impulsivity and compulsivity in problematic sexual behaviors. J Sex Res. 2019;56(2):166-179.
51. Voon V, Mole TB, Banca P, Porter L, Morris L, Mitchell S, et al. Neural correlates of sexual cue reactivity in individuals with and without compulsive sexual behaviours. PLoS One. 2014;9(7). doi:10.1371/journal.pone.0102419.
52. Mechelmans DJ, Irvine M, Banca P, Porter L, Mitchell S, Mole TB, et al. Enhanced attentional bias towards sexually explicit cues in individuals with and without compulsive sexual behaviours. PLoS One. 2014;9(8). doi:10.1371/journal.pone.0105476.
53. Gola M, Wordecha M, Marchewka A, Sescousse G. Visual sexual stimuli—cue or reward? A perspective for interpreting neuroimaging findings on human sexual behaviors. Front Hum Neurosci. 2016;10:402.
54. Gola M, Miyakoshi M, Sescousse G. Sex, impulsivity, and anxiety: interplay between ventral striatum and amygdala reactivity in sexual behaviors. J Neurosci. 2015;35(46):15225-15233.
55. Seok JW, Sohn JH. Neural substrates of sexual desire in individuals with problematic hypersexual behavior. Front Behav Neurosci. 2015;9:321.
56. Banca P, Morris LS, Mitchell S, Harrison NA, Potenza MN, Voon V. Novelty, conditioning and attentional bias to sexual rewards. J Psychiatr Res. 2016;72:91-101.
57. Stark R, Klucken T, Potenza MN, Brand M, Strahler J. Current understanding of the behavioral neuroscience of compulsive sexual behavior disorder and problematic pornography use. Curr Behav Neurosci Rep. 2018;5:218-231.
58. Brand M, Snagowski J, Laier C, Maderwald S. Ventral striatum activity when watching preferred pornographic pictures is correlated with symptoms of Internet pornography addiction. Neuroimage. 2016;129:224-232.
59. Kühn S, Gallinat J. Brain structure and functional connectivity associated with pornography consumption: the brain on porn. JAMA Psychiatry. 2014;71(7):827-834.
60. Schmidt C, Morris LS, Kvamme TL, Hall P, Birchard T, Voon V. Compulsive sexual behavior: prefrontal and limbic volume and interactions. Hum Brain Mapp. 2017;38(3):1182-1190.
61. Raymond NC, Coleman E, Miner MH. Psychiatric comorbidity and compulsive/impulsive traits in compulsive sexual behavior. Compr Psychiatry. 2003;44(5):370-380. doi:10.1016/S0010-440X(03)00110-X.
62. Kowalewska E, Gola M, Kraus SW, Lew-Starowicz M, Gustavsson K, Gola M. Spotlight on compulsive sexual behavior disorder: a systematic review of research on women. Neuropsychiatr Dis Treat. 2020;16:2025-2043. doi:10.2147/NDT.S221540.
63. Kowalewska E, Kraus SW, Lew-Starowicz M, Gustavsson K, Gola M. Which dimensions of human sexuality are related to compulsive sexual behavior disorder? Study using a multidimensional sexuality questionnaire on a sample of Polish males. J Sex Med. 2019;16(8):1264-1273.
64. Rosansky JA, Borgogna NC, Kraus SW, Grubbs JB. Cross-sectional and longitudinal associations between posttraumatic stress symptoms and hypersexual behaviors among individuals who have gambled in their lifetimes. J Sex Med. 2022;19(12):1813-1823. doi:10.1016/j.jsxm.2022.09.003.
65. Kopeykina I, Kim HJ, Khatun T, Boland J, Haeri S, Cohen LJ, et al. Hypersexuality and couple relationships in bipolar disorder: a

review. J Affect Disord. 2016;195:1-14. doi:10.1016/j.jad.2016.01.035.
66. Slavin MN, Blycker GR, Potenza MN, Bőthe B, Demetrovics Z, Kraus SW. Gender-related differences in associations between sexual abuse and hypersexuality. J Sex Med. 2020;17(10):2029-2038.
67. Miner MH, Romine RS, Raymond N, Janssen E, MacDonald A, Coleman E. Understanding the personality and behavioral mechanisms defining hypersexuality in men who have sex with men. J Sex Med. 2016;13(9):1323-1331. doi:10.1016/j.jsxm.2016.06.015.
68. Bőthe B, Tóth-Király I, Orosz G, Potenza MN, Griffiths MD, Demetrovics Z. High-frequency pornography use may not always be problematic. J Sex Med. 2020;17(4):793-811.
69. Hallberg J, Kaldo V, Arver S, Dhejne C, Jokinen J, Öberg KG. A cognitive-behavioral therapy group intervention for hypersexual disorder: a feasibility study. J Sex Med. 2017;14(7):950-958.
70. Hallberg J, Kaldo V, Arver S, Dhejne C, Jokinen J, Öberg KG. A randomized controlled study of group-administered cognitive behavioral therapy for hypersexual disorder in men. J Sex Med. 2019;16(5):733-745.
71. Hallberg J, Kaldo V, Arver S, Dhejne C, Piwowar M, Jokinen J, et al. Internet-administered cognitive behavioral therapy for hypersexual disorder, with or without paraphilia(s) or paraphilic disorder(s) in men: a pilot study. J Sex Med. 2020;17(10):2039-2054.
72. Antons S, Engel J, Briken P, Krüger THC, Brand M, Stark R. Treatments and interventions for compulsive sexual behavior disorder with a focus on problematic pornography use: a preregistered systematic review. J Behav Addict. 2022;11(3):643-666. doi:10.1556/2006.2022.00061.
73. Savard J, Görts Öberg K, Chatzittofis A, Dhejne C, Arver S, Jokinen J. Naltrexone in compulsive sexual behavior disorder: a feasibility study of twenty men. J Sex Med. 2020;17(8):1544-1552. doi:10.1016/j.jsxm.2020.04.318.
74. Wainberg ML, Muench F, Morgenstern J, Hollander E, Irwin TW, Parsons JT, et al. A double-blind study of citalopram versus placebo in the treatment of compulsive sexual behaviors in gay and bisexual men. J Clin Psychiatry. 2006;67(12):1968-1973. doi:10.4088/JCP.v67n1218.

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