

Compulsive Sexual Behaviors in a Young Male with Social Anxiety Disorder (Social Phobia)

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ABSTRACT

Compulsive sexual behaviours are relatively rare and are not known to be associated with social phobias, with an intense scientific debate on going if it constitutes a behavioral addiction. Compulsive sexual behaviours otherwise known as Hypersexuality/problematic sexual behaviour and is identified by a persistent pattern of failure to control repetitive, intense urges, fantasies and behaviours of a sexual nature over an extended period of time that causes marked impairment in multiple areas of functioning, in this case, especially educational functioning. Phobic anxiety disorders also known as social phobias are a group of conditions in which anxiety is triggered typically in well-defined situations that are not currently dangerous with resulting avoidance of such situations. Nevertheless, CSB is not captured in DSM V and ICD10, although, diagnostic criteria were proposed during DSM V revision, it is not currently recognized in the DSMV. Although, CSB has been proposed for inclusion in ICD 11 as an impulse control disorder, rather than as a mental and behavioural disorder as previously debated, in addition, strict diagnostic guidelines were instituted due to concerns of over pathologizing sexual behaviours. This presents a diagnostic and treatment dilemma for the psychiatrist when a patient presents with symptoms of Compulsive sexual behaviours with or without anxiety, since there are presently no diagnostic and treatment guidelines. We present the case of a 23 year old 3rd year medical student with a 5 year history of compulsive masturbation, persistent pornography viewing, failure to resist impulses and fantasies with accompanying intense distress especially following periods of abstinence and a two year history of recurrent panic attacks in social settings in which women were triggers complicated by depressive symptoms, symptoms significantly impaired most areas of functioning particularly his academics.

A diagnosis of Social Phobia/Social Anxiety disorder with episodic panic attacks and compulsive sexual behaviours and mild depressive episode was made because patient met criteria according to ICD 10 and proposed ICD 11. Mental state examination shows anxious mood, congruent with affect, depersonalization, derealization as well as anxious ruminations. Within a year, after commencement of an SSRI, Atenolol and Lisonopril and CBT all anxiety symptoms resolved with marked reduction in the frequency of pornography viewing as well as compulsive masturbation with associated fantasies. This case report lends voice to the on-going debate about the inclusion of compulsive sexual behaviours as a mental and behavioural disorder Dependence syndrome in diagnostic classification systems as well as the need for development of standardized appropriate treatment modalities. This case report will highlight Compulsive Sexual Behaviours, rationale for its inclusion as an addiction in classification systems and treatment approaches to the disorder.

Key words: Social Anxiety Disorder; Compulsive Sexual Behaviors; Social Phobiaprofessions

INTRODUCTION

Phobic anxiety disorders also known as social phobias are a group of conditions in which anxiety is triggered typically in well-defined situations that are not currently dangerous with resulting avoidance of such situations. The patient is usually distressed by symptoms

such as palpitations, fear of dying and fear of embarrassing oneself or fears of going crazy, these results in considerable distress and disrupts the patient's life with debilitating effects. Phobic disorders may coexist with panic attacks and depression as seen in this case. Compulsive sexual behaviours are relatively rare and are not known to be associated with social phobias, with an intense scientific

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debate on-going if it constitutes a behavioural addiction, it is also known as problematic sexual behaviour. Compulsive sexual behaviours otherwise known as Hyper sexuality/problematic sexual behaviours is identified by a persistent pattern of failure to control repetitive, intense urges, fantasies and behaviours of a sexual nature over an extended period of time that causes marked impairment in multiple areas of functioning, in this case, personal, family, social, educational settings. Nevertheless, CSB is not captured in DSM V and ICD10, although, diagnostic criteria were proposed during DSM V revision, it is not currently recognized in the DSMV. Historically, it was after Richard von Krafft-Ebing who described sexual behaviour in men that we had a description of sexual behaviour that mimics our modern understanding of CSB: "sexual instinct which permeates all thoughts and feelings, allowing of no other life...in a rut like fashion demanding gratification without granting the possibility of moral counter representations and resolving itself into an impulsive, insatiable succession of sexual enjoyment" (translated from German). Recent studies in the US show a prevalence rate of 3.7% among university students with symptoms consistent with current non paraphilic CSB. Another US study of 1,837 university students who were screened specifically for CSB criteria found a prevalence of 2.0% (3.0% for men, 2.0% for women). A recent Scandinavian study in Sweden involving the assessment of Internet sexual addiction shows a prevalence of 2% for women and 5% for men. The authors could not find any studies on CSB in African literature. Due to the embarrassing nature as well as shame that is frequently associated with CSB sufferers, it is difficult to evaluate. This is especially worse in the context of Nigeria and Africa as a whole since sex related disorders are viewed as a taboo for discussion even in private settings. Nevertheless, most individuals who seek treatment for CSB are males with a primary onset of CSB during late adolescence as exemplified in this case report.

However, CSB has been reported to be far more common among females than males (8.9% of females and 0% of males) shown in a study of 102 adolescents hospitalized for psychiatric reasons. There appear to be fewer differences in men and women with CSB/Hypersexuality than previously reported, a recent study show that both gender exhibited very similar characteristics and behaviours. SB can be subdivided into three clinical presentations: repeated sexual fantasies, repeated sexual urges and repeated sexual behaviour [1]. Black D. W et al showed that about 67% of the sample engaged in repeated sexual behaviours that they felt was out of control. Over half of those with CSB report that their thoughts, urges and behavior negatively affect other areas of their lives such as marriage, important relationships, works and social activities [2]. CSB can be understood to be an extreme form of behavior even if patient does not meet the full clinical description, it is important to recognize the symptoms; in this case report the patient met full criteria for CSB and several other psychiatric disorders.

The most common compulsive sexual behavior include masturbation (17-75%), followed by compulsive use of pornography (48.7-54%)(18, 17) and compulsive cruising and multiple relationships (22-76%)(11) importantly a wide range of behavior can co- occur but certain behaviors generally appear to be more common in those with CSB e.g masturbation and pornography use. Several specific mood states often trigger sexual behavior in CSB sufferers, depression (67%), happiness (54%) or loneliness (46%) as reported by Black D. W et al [2] both depressed mood and loneliness triggered compulsive masturbation and pornography use in the male in this case report.

Raymond N. C et al shows that 100% of CSB participants in one study had a lifetime prevalence of Axis I disorder with Depression being the most common as seen in this case report although Social phobia was prominent in this case report [3]. Several studies as well as a study on the applicability of substance use disorder criteria in sexual addiction show that 34% and 71% of individuals with CSB had comorbid substance use disorders, CSB can also be comorbid with impulse control disorders such as pathological gambling and compulsive buying. Majority of persons who suffer from CSB come from dysfunctional homes with about 86.8% and 77% were from disengaged and rigid families respectively.

A theory regarding CSB and dysfunctional family interactions suggests that as children the CSB patient's needs are unmet due to rigidity and failure to follow through these results in the child believing that they have to depend on themselves since parents are unreliable, in time, sexual activities become a source of wellbeing to CSB sufferers. Other research shows that physical and sexual abuse appears to be more prevalent in CSB patients with about 22% having a childhood history of physical abuse and 13% having a history of sexual abuse as compared to the general population. The effects of CSB can be very distressing to the sufferer and can interfere with different areas of the person's life, some sufferers experience a variety of medical conditions such as STIs, [4] unwanted pregnancy and physical injuries due to repetitive sexual activities e.g anal, vaginal and pencil trauma. Sexual compulsivity is linked to more unprotected sexual acts and a greater number of sexual partners [5-7] implying an increased risk of risky sexual behaviours.

A national survey on risk factors for lifetime suicide attempts showed that individuals with CSB appear to have a higher risk of suicide than the general population (19% versus 4.6%). However, a study by Harper C [8] among university students in Canada shows that addictive use of internet pornography is associated with poorer psychosocial functioning (depression, anxiety, life and relationship satisfaction) when people begin to use internet pornography daily, with no strong significant association between internet pornography use and general psychosocial functioning. The fact that there is a high prevalence of comorbid medical and mental health problems indicates that multiple mechanisms are involved in CSB apart from psychiatric psychopathology. Several recent studies strongly suggest that maladaptive cognitive processes and perceptions about sex are present in both homosexual and bisexual men. This was further supported by another study which indicated that these maladaptive processes were evident across a wide range of sexual orientations in which heterosexual, homosexual and bisexual men found potential cognitive differences where mindfulness was inversely related to hypersexuality which generated higher levels of impulsiveness and negative emotions. Treatment for CSB with or without comorbid Axis I disorders is unclear, usually the comorbidity indicates what treatment modality to use.

Making an accurate diagnosis is critical as there are medical causes of CSB which include Alzheimer's disease with sexual disinhibition, Pick's disease, Parkinson's disease [9] as well as some drugs such as dopamine agonists, Cocaine, GHB and methamphetamine.

Current evidence suggests that high levels of Norepinephrine, Serotonin and Dopamine are related to CSB, changes in brain reinforcement pathways occurs following CSB, these are possibly behind the neurobiology of CSB. Both psychodynamic and cognitive behavioural therapy approaches have shown some promise in case reports and case series for individuals struggling

with CSB. Pharmacological treatment has limited research findings, however, SSRIs in particular Citalopram has been shown to reduce sexual desire, frequency of pornography & masturbation use per week when compared to placebo among homosexual and bisexual males, studies were scarce among heterosexual males. In addition, Naltrexone when used in combination with an SSRI has been shown to successfully reduce sexual behaviors related to CSB. Support groups such as sex Addicts Anonymous (SSA) which is patterned along similar lines like the Alcoholic Anonymous 12 step program are also avenues used by CSB sufferers. Nevertheless, CSB either paraphillic or non paraphillic types is neither captured in DSM V nor ICD10, although, diagnostic criteria was proposed during DSM V revision, it is not currently recognised in the DSMV. This presents a diagnostic and treatment dilemma for the psychiatrist when a patient presents with symptoms of Compulsive sexual behaviours with or without anxiety, since there are presently no diagnostic and treatment guidelines.

CASE PRESENTATION

Biodata

Mr. Jorge, a 21-year-old 500 level Medical student, Christian, single, resident in Jos.

Information & Referral

Provided by the patient

Source of referral: self, seen in outpatient psychiatric clinic.

Presenting complaints

Excessive pornography viewing & masturbation x 5 years

Fear of death/humiliation/embarrassment in public x 2 years

Pounding heartbeat/shaking x 2 years

Sad feeling & feelings of guilt x 2 years

History

He was in his usual state of health until 5 years ago when he began viewing pornographic images and videos at age 15. He was introduced to porn use by his classmates who showed him a video of a couple having sex; he had approached them and asked them why girls don't like him, he masturbates using soap as lubricant, occasionally uses a pillow too, about 3-4 times per week, which increased over time to about 1-2 episodes per day, maximum episodes is about 6-7 times per day with or without ejaculation, increase in frequency has been because of an increased need for pleasure and because he wants more orgasms. He has experienced tension, angry outbursts, tremulousness, and flashbacks of pornographic images when he abstains from viewing pornography, which is relieved by viewing porn and almost always accompanied by masturbation. He has attempted to stop both viewing porn and masturbation but has been unsuccessful despite several attempts. Initial attempt was following completion of a Bible study course and because he didn't want to confess his sins as expected on completion of the course, he abstained for 3 weeks and relapsed due to flashbacks and an irresistible urge to masturbate. He has never told anyone about his habit and he no longer feels guilty about the habit for the past 4 years. Longest period of abstinence is 140 days, after he joined several online groups (support groups) on quitting pornography and masturbation. Psychosexual history shows that he attained puberty at age 13 evidenced by broadening

of the chest, enlargement of the genitalia and development of axillary and pubic hair and onset of nocturnal seminal emission. He is heterosexually oriented. Has not commenced sexual activity with anyone. Never had a girlfriend or romantic partner, he is afraid of asking girls out but wants a relationship with them. No history of hatred of women, no history of being unhappy about his gender, excessive use of females toys and distaste of his genitalia. No history of paraphillias. Sex education was obtained at school and through the media. He began watching pornography, after a female classmate refused to have him coach her in Chemistry at the suggestion of their Science teacher, he complained to his friends and they told him girls will like him if he can have sex so he began watching pornography in order to know about sex. Initially, he felt that the sexual activity depicted in the pornographic videos were impossible and found them repulsive but over time he found them pleasurable. Porn use was initially occasional; this gradually increased to weekly use, thrice a week and then to daily use within a year.

Since he got a phone, he watches pornography multiple times a day in multiple settings: at home, while commuting, at school during academic activities and he gets irritated when he cannot watch pornography or masturbate due to his location or circumstances. Content of porn was initially heterosexual Caucasians but over time he has expanded to Lesbians, sexual orgies involving multiple women and men. However, he doesn't watch sexual acts between men, humans and animals as well as child pornography and violent acts associated with sex. He has done everything to hide his habit for fear of what his parents and others will say, watching porn when no one is around, in the toilet as well as switching off the volume of his phone during use. He began masturbating a few months following pornography use, almost always associated with viewing pornography, triggers for masturbation includes:

- Surfing the internet for unrelated subjects
- Watching romantic movies
- Seeing couples together in real life
- Flashbacks from porn viewing
- Prolonged tension due to abstinence from pornography and masturbation
- Lying down
- Sight of pillows

He initially began by stroking his phallus up to the point of ejaculation, then with the use of lubricants, no use of sex toys. He began experiencing an undue fear of embarrassing himself in public and humiliation 2 years ago. Initial fear began when he was with a group of students of both genders.

He began experiencing a strange sensation, which he described as painful, tightening as if a band of wire is being constructed around his chest, there were associated feelings of breathlessness, a choking sensation in his throat as if an object is lodged in it, pounding of his heart audibly and uncontrolled shaking of his upper extremities. Over time, he began feeling that he is about to die. Initial episode was out of the blue, unexpected and lasted for about 10 minutes before gradually subsiding; this has gradually increased to about 15-20 minutes and worsening of associated effects and feelings; symptoms rapidly resolve if he leaves the immediate environment. Symptoms usually occur in social settings, almost always in the presence of young girls/women, in school and at church; also when

conversations revolve around sex. He has begun avoiding school and church in order not to precipitate an attack but still manages to attend both. There are associated feelings of being detached from the environment, sweating and being unreal which has worsened over the past year. He has about 2-3 episodes each week at the moment. He has also begun to have attacks while alone when he is reading and this affects his concentration and comprehension. Last episode was 2 days prior to presentation during a lecture, which he described as “terrifying.” He finds it difficult to go to the market, attend church & lectures, stay around girls because he is scared of embarrassing himself when conversing with people. There is a history of sad feeling, which is said to be occasional but has been progressively worsening, associated with crying, worse in the morning and improves as the day progresses. He believes he has a bleak future, and has death wishes and thoughts of killing himself by walking into a busy road in front of moving traffic in an express way. However, he has not attempted to kill himself because it is a sin in God’s eyes and this will hurt his parents neither has he told anyone about it. There is a history of loss of interest in previously pleasurable activities such as reading and watching TV with associated feelings of worthlessness. There are intense feelings of guilt and repeated begging for forgiveness directed to God, because of his addiction to pornography, this has reduced markedly over the last 4 years. Sleep has been poor, total sleep time is about 3-4 hours. He finds it difficult to fall asleep and wakes up earlier than usual.

There is a history of poor concentration, he finds it very difficult to read his books understand what he is doing and remember what he has read during examinations, and he is afraid he will fail out of medical School. Appetite, weight is unaffected. He strongly believes girls hate him because he is ugly, no history of belief in having misshapen facial features, body odour, halitosis, a need for plastic surgery, poor grooming and constant mirrow gazing over his appearance. No history of prescription drug use,, increased energy, overfamiliarity, increased generosity, increased self-esteem. No history of excessive sleep, excessive eating and daytime sleepiness. No history of hearing voices unheard by others, seeing things unseen by others in clear consciousness as well as abnormal taste/smell/body sensation, abnormal beliefs, deterioration of self-care, abnormal posturing, gathering of debris.

No history of cold/heat intolerance, voice changes, neck swelling, pins and needles sensations, loss of consciousness/awareness, convulsions, chest pain, cough, gastrointestinal and genitourinary symptoms.

Complications

He has gradually been deteriorating academically evidenced by failing grades, missing lectures and he desires a deferment from academic work as a result of compulsive sexual activities. He rarely attends lectures anymore and has desisted from going to church for the past 6 months due to the fear of panic attacks, embarrassing himself in public as well as self- condemnation when he is in church. Also, finds it difficult interacting with family members and socializing generally.

Interventions

He has gone for prayer sessions several times in multiple churches/spiritual houses, all to no avail. He has also fasted and prayed but has had repeatedly relapses on both masturbation and pornography

with no improvement. He feels no one understands what he is going through. He saw a doctor in a peripheral centre and antidepressants were prescribed. He has joined several online support groups for pornography and masturbation addicts such as nogap.com, ybop.com, yourbrainrebalanced.com, elevatedrebio.com, this has helped on a temporary basis but he had returned to pornography viewing and masturbation due to an irresistible desire and also triggered by cues. He presented to this facility due to progressive worsening of symptoms and for expert management.

- Past Psychiatric History
- First episode of mental illness
- Past Medical and Surgical History
- Known hypertensive, diagnosed 2 years ago
- Currently on medication.
- Family & Personal History

He is the first of 6 children in a monogamous Christian setting in a religiously divided household. His father is a 50-year-old Medical Practitioner, Catholic, resident in a nearby town. His mother is a 46-year-old homemaker with tertiary level of education. She is a Protestant, of the Pentecostal denomination. He has three brothers & two sisters in total; the youngest is about 5 years. No family history of mental illness. No family history of substance use. Positive history of each parent wanting him to follow his/her religion but no conflict over this. No history of physical, emotional, sexual abuse.

Personal History

- His conception, pregnancy, intrauterine life was essentially uneventful and normal.
- He was fully immunized and to the best of his knowledge, didn’t have any illnesses while growing up.
- He commenced nursery school at age 2 and completed his primary education in record time.
- He was an above average student.
- He commenced secondary school at age 11 and completed high school with 9 subjects at O levels (6 distinctions and 3 credits in the final secondary school examinations.)
- He was in the upper stream throughout secondary school.
- He proceeded to a nearby university of Jos to study Medicine and is currently in 300 levels, he lives with a roommate in a studio apartment.
- Psychosexual History
- As documented in history of presenting complaints.
- Substance Use History
- He doesn’t use alcohol or any other psychoactive substances.
- Forensic History
- Has not been involved with law enforcement agents or charged to court.
- Premorbid Personality
- By self-assessment, since no relatives were available.

- He described himself as a shy, quiet, reserved young man who has few close male friends; he has no female friends although he wishes to.
- A bookworm/geek.
- Relates well with family members.
- Hardworking and intelligent.
- Religious,
- Leisure spent reading and watching movies.
- Ultimate goal is to be successful
- Prevailing mood: happy
- Mental State Examination

Appearance & Behaviour

A young male, slim, dark in complexion, average height & body build dressed in a T-shirt and black jeans, in good nutritional status, kempt, good eye contact, cooperative.

- Anxious demeanour with difficulty keeping his legs still and repeatedly unfolding and folding his sleeve
- Speech: Responsive, normal tone & normal volume, coherent and relevant.
- Mood: "I am either anxious & sad." (In his ownwords)
- Affect: Anxious, congruent with mood.
- Thought Stream: Normal.
- Thought Form: No formal thought disorder.
- Thought Content: Thoughts revolve around fear of dying, academic problems due to poor concentration, Desire to watch pornography & Fear of being discovered watching pornography.
- Thought Possession: Nil anomalies of possession
- Perception: Depersonalization & Derealisation.

Cognition

Conscious, alert, fully oriented in time, place and person. Attention & concentration: Can do serial 7. Registration: Registered the statement "Hajia Gambo No. 7 Lafia St. New York" Recall: Good. Intelligence Abstraction: Could interpret the proverb correctly, "Don't watch the family's dirty linen in public." Fund of Knowledge: Identifies the President of Nigeria correctly & aware of recent events on the news.

- Arithmetic Skills: Can do simple sums
- Judgement: Intact, both subjectively & objectively
- Insight: Full
- General Physical Examination: A young man, not in any form of painful or respiratory distress, not pale, anicteric, not cyanosed, nil finger clubbing, with an axillary temperature of 36.8oC with no pedal oedema, with restless legs
- CNS CVS
- Conscious, alert PR: 120 bpm
- Oriented in time, place BP: 140/100 mmHg sitted

- Nil signs of meningeal irritation. S1 and S2 heard
- Nil focal neurological deficits
- Chest
- Respiratory rate: 18cpm
- Chest is clinically clear
- Abdomen
- Flat, moves with respiration
- Inverted umbilicus
- Nil areas of tenderness

DIAGNOSTIC FORMULATION

Mr. Jorge is a 21-year-old single 300 level Medical student, Nigerian Christian who presented in the Psychiatric Outpatient Department with a 5-year-history of Compulsive masturbation associated with persistent pornography video viewing failure to resist sexual impulses, fantasies about sex, with distress, irritability and anxiety following abstinence from masturbation & pornography and a 2 year history of recurrent panic attacks characterized by:

- Angor animus
- Globus hystericus
- Palpitations
- Breathlessness
- Tremulousness

Usually triggered by social settings in which the opposite sex is present with gynophobia with associated depressive symptoms, depersonalization and derealisation, depressed and anxious affect, with BP within the hypertensive range & tachycardia in a known hypertensive compliant with medication.

DIAGNOSIS

Axis I:

Social Phobia with panic attacks
2. Compulsive Sexual Behaviour
3. Severe depressive episode without psychotic symptoms was made.

Axis II:

Disability in personal, household, family, educational and social setting

Axis III:

Predisposing Factor: personality disorder

Precipitating Factor: Supposed rejection by girls.

Perpetuating Factor: Poor social support and Poor academic performance

PLAN

- Full blood count and differentials
- Liver function tests
- Electrolytes, Urea and Creatinine
- Urine Toxicology

- Electrocardiography
- Personality Testing via MMPI
- For Social Investigation of family and social circumstances
- Tab Lisinopril 10 mg daily
- Tab Amitryptiline 50 mg nocte
- Tab Atenolol 50 mg daily
- Tab Citalopram 10mg daily x 1/52

Cognitive Behavioural Therapy: Modification of thinking errors, self-monitoring, progressive muscle relaxation and assertiveness training. Social Skills Training: Phobic avoidance by exposure; Relaxation; Graded exposure to women in social settings. Motivational Interviewing: Done.

Progress

Within a year, all anxiety symptoms resolved with marked reduction in the frequency of pornography viewing as well as compulsive masturbation with associated fantasies. From the 13th month since presentation until date, he has resumed academic activities and he has no compulsive sexual behaviour relapses and has been compliant with medication. Although, cognitive behavioural techniques such as self-monitoring, muscle relaxation and assertiveness training to improve socialization with women were introduced, this couldn't be sustained because the patient returned to his parents' home in a distant city.

DISCUSSION

The findings from the patient review show that compulsive sexual behaviour is not an uncommon condition with or without comorbid Anxiety disorders and Depression. The findings in this case report agree with the fact that mood States such as being sad or lonely can trigger problematic sexual behaviours and Depression is the commonest Axis I disorder associated with CSB, however, there was a paucity of research findings indicating an association between CDB and Anxiety disorders.

Our patient had no history of psychoactive substance use either as a coping mechanism or used in the context of cross addiction despite some studies showing a significant comorbidity of lifetime substance use disorders seen among CDB sufferers. This patient comes from a religiously divided home with some rigidity about sexuality, research indicates that a significant proportion of CSB sufferers emerge from rigid disengaged dysfunctional homes, a possible aetiological theory for the development of CSB in later life although, there was no history of physical & sexual abuse was seen in this patient, it was observed that a high proportion of CSB patients had higher rates of abuse when compared to the general population in the US. In our patient and in many other cases, compulsive sexual behaviours did commence in adolescence and the overwhelming majority of CSB sufferers have loss of control, gratification from sexual behaviours and an easing of tension afterwards. Sexual fantasies, compulsive use of pornography as well as masturbation are a few of the broad range of problematic sexual behaviours seen in CS the aforementioned trio of common presenting complaints were observed in this patient, this was in far excess of what is considered normal and interfered with virtually every aspect of our patient's life. Our patient met clear cut criteria for Dependence syndrome, under Mental and Behavioural

disorders evidenced by the presence of irresistible craving for sexual behaviours, withdrawal symptoms after cessation of sexual activities, prolonged duration lasting over 12 months (in this case 5 years) and affectation in multiple areas of life criteria for Dependence syndrome under Mental Behavioural disorders in ICD10 and in the proposed ICD 11 under impulse control disorder.(icd 10 ref) as well as Dependence syndrome under DDM-5 (DSM-5 2013). Although, there is some data supporting the hypothesis that CSB can be classified as an impulse control disorder, it is worthy of note that only a minority of CSB sufferers have comorbid impulse control disorder such as pathological gambling compulsive buying, however, compelling evidence shows majority of CSB patients satisfy majority of the diagnostic criteria for dependence syndrome of both ICD and DSM classification systems overwhelming (ICD 10, DSM -5) with multiple affectation in all areas of life identical to substance use disorders. Research is limited about drug based therapies for CSB, our patient however, had significant reductions in the problematic sexual behaviours following several months of SSRI, although, the only study that showed reduction in sexual desire and behavior following Citalopram use (an SSRI) was conducted among bisexual and homosexual males, it is known that SSRI reduce CSB symptoms irrespective of sexual orientation, our patient was heterosexually oriented and has not had a relapse for the past 13 months since presentation. Diagnostic criteria for DSM-5 Hypersexuality which is used interchangeably with CSB seems to reflect criteria for substance use disorders, although a description similar to CSB/ Hypersexual disorder can be made as "pathological sexuality" in ICD 6 since its inception in 1948.

Nonetheless, there are serious challenges and issues with classifying CSB as an addiction due to lack of uniform definitions, lack of research that controls for confounds, and absence of an established divergent validity from related psychiatric phenomena such as paraphilic disorders.

Currently, CSB has been proposed for inclusion in ICD 11 as an impulse control disorder, rather than as a mental and behavioural disorder as previously debated, in addition, strict diagnostic guidelines were instituted due to concerns of over pathologizing sexual behaviours. With the exclusion of CSB from DSM-5, the issue of the best way to conceptualize CSB has not been resolved and despite the reclassification of Gaming disorder as a Behavioural addiction in DSM-5 and non-inclusion of CSB as a behavioural addiction, this has raised questions as to what constitutes an addiction despite this many clinicians have suggested that CSB should be included as a candidate for Behavioural addiction. As in this case, many CSB sufferers from the community seek treatment in frameworks such as Sexaholics anonymously on the internet [10-11] especially as the impairment affects multiple aspects of his life. More research needs to be conducted about the prevalence, knowledge, classification diagnosis and treatment of CSB as well as education about CSB among mental health professionals.

There is compelling evidence to include Compulsive Sexual behaviour in psychiatric classification systems on its own right or under Dependence syndrome in the proposed ICD 11 or future classification systems in the DSM system.

CONCLUSION

CSB unlike phobic anxiety has defied categorization within psychiatric nosology for years; this has made research into treatment very difficult, further research needs to be done as the

understanding of compulsive sexual behaviours evolves as further research elucidates the phenomenology and neurobiological underpinnings of the condition.

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