

Compulsive sexual behavior disorder in Bangladesh: a case-based exploration of clinical presentations and treatment

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Summary

The new ICD-11 classification for compulsive sexual behavior disorder (CSBD) is defined by strong, repetitive sexual urges that result in a recurrent pattern of sexual conduct that is accompanied by suffering or impairment. This case series examines three Bangladeshi patients with CSBD across distinct developmental stages (childhood, early & late adulthood), demonstrating the disorder's heterogeneous manifestations and multifactorial etiology. The A-B-C model – affective dysregulation, behavioral addiction, and lack of cognitive control – provides a framework for understanding these presentations, with emotional states like boredom and stressful situations. Comorbidities aligned with prior research included mood disorders such as depression in Case 1 and anxiety in Case 2, reinforcing connections between CSBD and broader psychiatric vulnerabilities. Treatment combined cognitive-behavioral therapy (CBT) targeting maladaptive sexual scripts, pharmacotherapy (SSRIs for impulsivity/OCD; low-dose antipsychotics for obsessive thoughts), and culturally adapted family interventions. CBT's effectiveness in addressing behavioral reinforcement cycles was particularly evident in Case 3's pornography-to-risky-sex progression. Sociocultural factors profoundly influenced presentations; stringent sexual norms in Bangladesh exacerbated shame, delayed help-seeking, and complicated clinical discussions, especially for female patients and childhood cases. Despite its limitations, the series highlights the clinical complexity of CSBD, underscoring the need for integrated biopsychosocial approaches. It advocates for clinician training in culturally sensitive, nonjudgmental assessment, particularly in conservative settings where sexual health stigma remains prevalent. The cases also highlight the evolving impact of digital accessibility on CSBD phenotypes, necessitating updated therapeutic strategies addressing online sexual behaviors.

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Introduction

Compulsive Sexual Behavior Disorder (CSBD) represents a complex clinical entity characterized by persistent failure to control intense sexual impulses, urges, and thoughts, resulting in repetitive sexual behaviors that cause marked impairment across important life domains.¹ Hypersexual disorder is described as non-paraphilic excesses of sexual desire and activity with an impulsivity component and accompanied by clinically significant personal distress, and social and medical morbidity.² The estimated prevalence rate in the general population is 3-6%.³ Problematic behaviors include excessive masturbation, cybersex, pornographic sex, sexual behavior with consenting adults, telephone sex, strip club visitation, and others.³

There is a difference of opinion among experts on how and where to include hypersexuality among the American experts;

hence, they are unable to include it in the Diagnostic and Statistical Manual of Mental Disorders-5(DSM-5).¹ A diagnosis for “hypersexual disorder” was proposed for the DSM-5 in 2010 by Martin Kafka, but ultimately was not included as a standalone diagnosis due to significant debate about whether CSBD should be categorized as an impulse-control disorder, an obsessive-compulsive disorder, or as a behavioral addiction.^{2,4} The lack of consensus on its conceptualization contributed to its exclusion.^{4,5} In 2018, reflecting emerging evidence, the WHO included CSBD as a new diagnosis in the ICD-11 under Impulse Control Disorders.

The status of CSBD has further complexity in Bangladesh, where the expression of sexuality is prohibited and tabooed. Despite its recent inclusion in the ICD-11, significant gaps remain in understanding the diverse clinical presentations and

developmental trajectories of this condition across different age groups. Given the severe personal, familial, and social consequences of such behaviors, the use of appropriate screening tools, accurate assessment and diagnosis, and the development of an effective treatment model for sexual addiction or compulsive sexual behavior (CSB) are of paramount importance.³

The three presented cases collectively highlight the clinical heterogeneity of CSBD and related maladaptive sexual behaviors across different age groups, genders, and sociocultural contexts in Bangladesh. It also provides an invaluable framework for documenting the natural clinical course and treatment responses in CSBD, particularly given the sensitive nature of sexual behaviors that may lead to underreporting in larger epidemiological studies.

Case summaries

Case 1

A 25-year-old young heterosexual Muslim female was admitted to a private psychiatric hospital in Bangladesh with complaints of problematic and maladaptive sexual behavior despite detrimental consequences for 9 years. She was also suffering from harmful & excessive use of multiple substances for a long duration.

From early childhood, she was exposed to parental abandonment, inadequate care, and neglect, along with frequent interparental conflicts. Following her mother's remarriage and relocation, she was emotionally distressed and felt lonely, which preceded the initiation of sexual activity at the age of 14. Since her first sexual encounter with a male classmate, she has been experiencing repeated and intense sexual urges that began early in her life. What initially appeared to be an isolated incident of maladaptive coping progressed into a pattern of recurrent non-paraphilic sexual activity involving either multiple partners or masturbation since that early age. The Hypersexual Behavior Inventory (HBI) yielded a score of 76, which significantly surpasses the commonly cited clinical cut-off of 53, as proposed by Reid and Garos for identifying clinically significant hypersexuality.⁶ This threshold has shown high sensitivity in detecting individuals with problematic sexual behaviors. Consequently, a score of 76 not only exceeds this benchmark but also signals an elevated level of hypersexual tendencies.⁶

Aligned with the criteria for CSBD, she exhibited a persistent preoccupation with intense sexual urges and fantasies occurring nearly every day. These urges prompted compulsive behaviors, including excessive shopping for clothing and engaging in elaborate grooming rituals. Her heightened sexual activity and frequent partner transitions resulted in severe physical, social, and occupational consequences, yet she remained unable to regulate or terminate the behavior.

She has lacked stable romantic relationships to date, suggesting possible attachment difficulties, paralleled by her pattern of polysubstance use. A significant portion of her sexual encounters took place within settings marked by shared substance use, where she often interacted with unfamiliar male partners. These behaviors reflect a cycle of impulsive sexual activity and substance dependence, where each may reinforce the other, contributing to compulsive sexual behavior and sustained substance misuse.

Her pattern of hypersexual behavior appears to have originated during early adolescence, at a time when there was no evidence of a concurrent substance use disorder (SUD). Subsequently, she developed SUD; however, the compulsive sexual behaviors persisted alongside the substance use rather than emerging as a secondary phenomenon. This temporal sequence suggests that her hypersexual behavior is an independent clinical feature, co-occurring with SUD, rather than a consequence of it. While CSBD & BPD (borderline personality disorder) both conditions may share impulsivity and issues with emotional regulation, there were no symptoms such as intense fear of abandonment, rapidly shifting moods, identity disturbances, or self-harm.

Initially resistant, she demonstrated increased readiness to change post-admission as insight developed through motivational interviewing. A personalized treatment plan was initiated, incorporating polysubstance use management, pharmacological treatment (SSRI), and cognitive behavioral therapy (CBT). Her awareness of the negative personal and social consequences was emphasized, and her strengths were highlighted. Fluoxetine (20 mg/Day) and olanzapine (5 mg/Day) were continued for the first month. Following an initial improvement, olanzapine was discontinued, and low-dose topiramate was introduced, given the patient's weight concerns. This revised regimen was maintained for 2–3 months.

Case 2

A seven-year-old female from a middle-class background, currently in the first grade, presented with a two-year history of episodic, stereotyped posturing. This involved thigh-tightening and suprapubic friction against external objects (hands, bedding, and pillows). These behaviors primarily occurred during periods of solitude or boredom. Over the three months preceding consultation, frequency escalated to 15–20 daily episodes, each lasting 5–10 minutes, resulting in social withdrawal and a marked decline in previously excellent academic performance.

Before seeking psychiatric intervention, the parents—driven by sociocultural shame—employed harsh punitive measures to suppress what they perceived as socially deviant behavior. They eventually sought help after facing stigmatization from relatives and school authorities. Clinical interview revealed the

child felt significant ego-dystonic shame regarding her actions but reported an inability to inhibit the urges. Her developmental and intellectual milestones were age-appropriate, and there was no evidence of sexual abuse, seizures, or movement disorders (e.g., paroxysmal dyskinesia). Notably, she exhibited comorbid obsessive-compulsive symptoms, specifically contamination anxiety and ritualistic handwashing, over the past year. Although comorbid obsessive-compulsive symptoms were present, the gratification behaviors were phenomenologically distinct from OCD compulsions. The episodes were not preceded by intrusive, anxiety-provoking sexual obsessions, nor were they performed to relieve anxiety or prevent feared outcomes. Instead, they typically occurred during states of boredom or inactivity and appeared to serve a self-stimulatory or regulatory function, consistent with gratification disorder rather than an OCD-related compulsion.

A diagnosis of Obsessive-Compulsive Disorder (OCD) with comorbid Gratification Disorder also known as Childhood Masturbation (CM), was established. While the DSM-5 does not classify childhood masturbation as a formal disorder, it is recognized as clinically significant when it becomes excessive or inappropriate for the developmental stage.⁷ The National Center on Sexual Behavior of Youth identifies excessive masturbation as a form of inappropriate sexual behavior in children aged 12 and under.⁸

Management involved comprehensive psychoeducation for the parents to shift from punitive to supportive behavioral reinforcement. Pharmacotherapy was initiated with fluoxetine (20 mg) and low-dose risperidone (0.5 mg). Following four individual sessions and two parental counseling sessions, the patient demonstrated improved impulse control.

Case 3

A 42-year-old married businessman of high socioeconomic status was referred by his wife due to a five-year history of compulsive pornography consumption and subsequent marital dysfunction. The patient presented with secondary sexual dysfunction, specifically premature ejaculation and erectile insufficiency during intercourse, despite hypersexual behaviors in isolation.

Collateral history from the wife indicated a progressive behavioral shift starting five years prior, characterized by social withdrawal, neglect of occupational responsibilities, and isolation. The patient reported a compulsive cycle of internet-based pornography use followed by excessive masturbation. Despite repeated attempts to achieve abstinence, the behavior escalated to frequenting massage parlors for commercial sexual encounters. To conceal these activities, the patient engaged in chronic pathological lying and avoided familial intimacy.

Psychosocial assessment revealed an introverted personality and an emotionally distant relationship with a dominant father, though no overt childhood trauma or abuse was identified. Mental state examination confirmed the patient was well-groomed, anxious, and expressed profound regret (ego-dystonicity) regarding his inability to control sexual urges. There was no evidence of psychosis, substance use disorders, or other behavioral addictions (e.g., gambling). He was treated with a combination of paroxetine (titrated to 40 mg/day), olanzapine (2.5 mg/day), and Cognitive Behavioral Therapy (CBT) targeting maladaptive sexual scripts. After 8 weeks of pharmacotherapy and 8 sessions of CBT, the patient showed some improvement in controlling compulsive sexual behaviors, with partial reduction in pornography use and risky sexual activities, and modest improvement in sexual functioning and relational engagement.

Discussion

This case series presents three individuals with heterosexual orientation and diverse presentations of CSBD. The cases illustrate how CSBD manifests in childhood, adulthood, and middle age, with each case requiring a tailored treatment approach involving psychotherapy, pharmacotherapy, and family support.

The A-B-C model—comprising Affective dysregulation (A), Behavioral addiction (B), and Cognitive control deficits (C)—provides a robust framework for conceptualizing these cases⁹. In Case 1, early parental neglect and emotional abandonment contributed to the development of risky sexual behavior, highlighting the role of childhood trauma. This supports studies connecting insecure attachment, trauma, and affective dysregulation to compulsive sexual behavior. Many individuals with hypersexual disorders also have mood and anxiety disorders. Black and colleagues found high comorbidity, including lifetime substance use disorders (64%), anxiety disorders (50%), and mood disorders (39%) in those with uncontrollable sexual behavior.¹⁰ Neurodevelopmental and behavioral factors played a more significant role in Case 2, where the child exhibited compulsive masturbation in the context of early-onset OCD. Childhood masturbation is often associated with experiences of sexual abuse.¹¹ The most common emotional states reported in which they masturbated were boredom and agitation.¹² However, evidence specifically connecting childhood masturbation to CSBD remains limited and complex. Early childhood masturbation is typically normal, but excessive or distressing behavior can be linked to CSBD in later life.¹² Here, sexual behavior was less about gratification and more about ritualistic behavior and impulse dysregulation. Importantly, this distress appeared to be externally driven and socio-culturally mediated, rather than arising from an internal obsession–compulsion process as seen in OCD.

In case 03, the researchers didn't find any association of childhood trauma or abuse or neglect. However, the patient's father exhibited a dominant demeanor, which may have influenced the course of this case. Although pornography use and marital dysfunction were prominent, the presentation was consistent with Compulsive Sexual Behavior Disorder rather than a secondary consequence, as evidenced by pervasive, ego-dystonic compulsive sexual behaviors extending beyond a single modality. The temporal progression and functional impairment indicate that pornography use and relationship difficulties were manifestations of the underlying disorder rather than primary causes.

In an era of unfettered Internet access on mobile devices, such behaviors as pornography use and casual sexual encounters appear to have become more prevalent. These factors contribute to a range of behaviors, such as paid sexual services as interpersonal behaviors, and binge pornography use and masturbation as solitary behaviors. In Case 3, the adult male's progression from pornography to real-life risky sexual behavior was driven by behavioral addiction, with reinforcement cycles, marital dissatisfaction, and poor coping strategies playing key roles. The cases also underscore the sociocultural context of Bangladesh, a predominantly Muslim country where sexual behavior is highly stigmatized, particularly outside the bounds of marriage. For example, women engaging in non-marital sexual behavior in case 1 face social rejection and culturally driven discomfort around discussing sexual development in case 2.

Treatment strategies varied across the three cases, with all patients receiving psychotherapeutic interventions, primarily CBT and behavior modification therapy. These served as the cornerstone across cases, targeting maladaptive thought patterns, sexual scripts, and behavioral reinforcements. Only eight sessions of behavioral therapy produced a marked improvement, which is both notable and clinically meaningful. Pharmacological intervention with SSRIs, such as Fluoxetine, Paroxetine, and escitalopram, proved effective in mitigating sexual preoccupation and impulsivity. These also address comorbid OCD in Case 2, along with mood-related symptoms in Cases 1 and 3. Additionally, low-dose atypical antipsychotics, including risperidone and olanzapine, were employed as adjunctive treatments. Relapse prevention planning emphasized lifestyle modification, building healthy relationships, and promoting structured routines. Reducing shame among patients and setting priorities in life are important. The breach of trust may leave the partner emotionally overwhelmed, especially when discovered during their dedicated support of the patient's treatment. The unfolding truth can severely damage the relationship, making disclosure emotionally and ethically complex.

The treating physician faces a dilemma—aware of the client's multiple deceitful relationships, while the unaware partner repeatedly seeks clarity and guidance on how to approach disclosure. Many therapists practice the CSBD treatment model of addiction. Prepare and encourage the patient to reveal himself about the hypersexuality activities beyond their relationship at the second stage of recovery (amendment phase), when he is more confident than in the first stage (wear and tear), before moving to the stage of growth and development.¹³

The small sample size and non-random selection limit generalizability in these case series. Also, the retrospective nature of data collection may introduce recall bias, particularly in the sensitive area of sexual behaviors. Despite these limitations, our findings have important clinical implications. They underscore the necessity of training healthcare professionals to recognize and manage CSBD in a nonjudgmental, evidence-based manner.

Conclusion

This case series highlights the complex clinical presentation of CSBD within the specific sociocultural landscape of Bangladesh. Our findings suggest that CSBD is often intertwined with early childhood adversity, obsessive-compulsive traits, and evolving digital consumption patterns. The successful management of these cases through an integrated biopsychosocial approach—combining CBT, targeted pharmacotherapy, and culturally adapted family interventions—underscores the necessity of a multimodal treatment framework. Limited sessions of behavioral therapy yielded substantial improvement—an outcome that is both notable and clinically significant. This underscores the value of a holistic approach, particularly as such patients typically require more prolonged courses of motivational interviewing and behavioral interventions. Moreover, although CSBD is usually more prevalent in late adolescence and early adulthood, especially among males, these findings present a meaningful deviation from established patterns. Despite increasing exposure to digital content and shifting social dynamics in South Asia, CSBD and related disorders are likely underdiagnosed. There is a pressing need to destigmatize sexual and behavioral health and build clinician capacity in sexual psychiatry to improve outcomes.

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