

## **Compulsive Masturbation Treated With Selective Serotonin Reuptake Inhibitors**

**Naif Abdullah Alsughier**

AlRass General Hospital, Qassim, Saudi Arabia

### **\*Corresponding author**

Naif Abdullah Alsughier

Email: [dr--naif@hotmail.com](mailto:dr--naif@hotmail.com)

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**Abstract:** Masturbation is considered as a normal stage of psychosexual development. It becomes abnormal when its frequency indicates a compulsion or sexual dysfunction, or when it is consistently preferred to sex with a partner. This case report describes 23 years old male student presented with penile erythema and skin abrasions due to excessive masturbation. It was diagnosed as specified sexual dysfunction (compulsive masturbation) according to DSM-V. This case treated with SSRI, initially with fluoxetine then shifted to paroxetine because of complaint of side effects. SSRI also used to treat the comorbid generalized anxiety disorder which can help managing the case of compulsive masturbation. There are few trials of different medications have been used to treat compulsive masturbation. This case responded well to paroxetine and combined use of both supportive psychotherapy and behavioral modification. Physical injury and penile inflammation can be a complication of repeated masturbation as in this case.

**Keywords:** compulsive masturbation, compulsive sexual behavior, case report, generalized anxiety disorder, selective serotonin reuptake inhibitors, Saudi.

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### **INTRODUCTION**

Masturbation or autoeroticism can be defined as achieving sexual pleasure that results in orgasm by self. Masturbation is a normal activity that is common in most stages of life, but this viewpoint was not always accepted. Freud believed that neurasthenia was caused by excessive masturbation. In the early 1900s, masturbatory insanity was a common diagnosis in hospitals for the criminally insane in the United States. Masturbation is abnormal when it is the only type of sexual activity performed in adulthood, when its frequency indicates a compulsion or sexual dysfunction, or when it is consistently preferred to sex with a partner[1].

Compulsive masturbation does not have a distinct diagnostic code but can be classified as other specified sexual dysfunction[2]. The classification of I.C.D has a diagnostic category called “excessive sexual desire” and compulsive masturbation disorder may fall into this category[3]. Compulsive sexual disorders are characterized as a behavioral addiction and also as an obsessive-compulsive spectrum disorder. They are quantified using the statistic of total sexual outlet ( the number of orgasms per week). Patients with compulsive sexual disorders referred for treatment generally if they show a total sexual outlet of >7[4]. Early psychological trauma, from sexual or physical abuse, exposure to violence, attachment trauma, or early sexualization, is known to be predisposing factors for sexual compulsive disorders[5].

Compulsive sexual disorders frequently have associated comorbidities of mood disorders 33%, anxiety disorders 42% , substance abuse disorders 29% and Personality disorders 46% [6,7]. Physical injury in compulsive masturbation is common. Patients with this disorder may masturbate 5–15 times a day and loneliness is felt keenly after an orgasm. This disorder can interfere in occupational, social, interpersonal, and intimacy functioning. Many different medications were cited in case reports as helpful in treating compulsive sexual disorders: lithium, tricyclic antidepressants, selective serotonin reuptake inhibitor(SSRI), atypical antipsychotics, naltrexone, mirtazapine, and topiramate[4].

### **CASE DESCRIPTION**

Mr. S, a 23 years old male student referred from urology clinic as the patient has penile erythema and skin abrasions due to excessive masturbation. He has a long history of excessive uncontrollable masturbation since 10 years comorbid with symptoms suggestive of generalized anxiety disorder. He is living with his family and his parents were overprotective since his early age. He had started masturbation when he was 13 years old associated with guilt feeling after each time he masturbates and he wanted to quit this habit. Repeated masturbation had affected his academic performance and he used to remain preoccupied most of the day with sexual thoughts. He attributed all his symptoms to the masturbation. He was observed by his family that he stays most of the day at his own room alone to watch pornographic movies. Initially at the age

of 13 years, the frequency of masturbation was once daily. The frequency of masturbation gradually increased to 8-10 times per day and used to spend long time in the bathroom. In the last year, when frequency of masturbation increased, his study affected and his marks dropped. Also he started to be socially withdrawn. The patient tried to stop this habit but without success. Despite he feels this act is pleasurable but after the ejaculation he becomes dysphoric and feels guilty. There were no other symptoms of compulsive or impulse nature and no history of symptoms suggestive of mood episodes. He was never treated in the past. There was no history of significant medical or surgical illness and no positive family history of any psychiatric illness. During the interview he was anxious, agitated and distressed. He had low self esteem, excessive worry, preoccupied by this habit and its consequences. All routine investigations were done that yielded normal results.

The patient's physical complaints (penile erythema and skin abrasions) were treated by urologist with topical medication.

The patient was diagnosed as having other specified sexual dysfunction "compulsive masturbation" as per the D.S.M.- V Classification [2]. He was started on Fluoxetine 20mg/day that was increased to 40mg/day after one week. Clonazepam 0.5 mg/day was added (tapered off over next 2 weeks). At the end of 3rd week, he showed an improvement and his masturbatory frequency decreased to 5-6 times per day. He asked to discontinue fluoxetine because of its side effects (restlessness and insomnia). He was shifted to paroxetine 12.5 mg/day for one week then increased gradually to 37.5mg/day within one month duration and psychology referral was made for behavioral therapy and supportive psychotherapy to help him to build his self esteem. At the end of 10th week of starting paroxetine his masturbatory frequency decreased to 1-3 times per week and his anxiety symptoms improved as well.(table 1) His academic performance returned to his baseline.

**Table1: Masturbatory frequency before and during treatment with paroxetine.**

Time	Masturbatory Frequency
Before starting treatment	8-10 times/day
After 3 weeks of starting fluoxetine	5-6 times/day
After 2 weeks of starting paroxetine	5-6 times/day
After 6 weeks of starting paroxetine	1-3 times /day
After 10 weeks of starting paroxetine	1-3 times/week

## DISCUSSION

According to D.S.M.-V compulsive masturbation can be classified as other specified sexual dysfunction[2], but in some references it is considered as an impulse control disorder[4] and other researchers consider it as variant of obsessive compulsive disorder[8] in which there is a phenomenological overlap of features of compulsive masturbation among these disorders[9]. There is scarcity of literature even in extensive reviews on compulsive sexual behaviors, and the disorder itself is rare[10,11] and there are no epidemiologic studies of prevalence of compulsive masturbation[12]. Patients with compulsive masturbation often present for treatment because the activity begin to consume many hours a day, interfering with work or a relationship[9]. Before initiating treatment in any form, the motivation of the patient for treatment must be established. Treating the premorbid conditions is also a pre-requisite to help the patient in managing his sexual problem. No randomized, controlled clinical trials on the medical treatment of this disorder were found in the literature review though anecdotal case reports exist. SSRIs are used for treatment for sexual compulsive disorders. Initially the SSRIs were tried because of the fact that their sexual side effects can be helpful in these compulsions. However, research suggests that decrease in symptoms

is independent of sexual side effects and is a result of their anti-obsessional effects or a reduction in thoughts and urges. This is important, because an ideal treatment would suppress deviant and uncontrollable sexual drives and behaviors but leave normative sexual interest and behaviors intact. There is no evidence that the SSRIs differ in efficacy. [13] Many cases reported that were successfully treated with SSRIs like fluoxetine , sertraline[14] and escitalopram[15]. Other medications can be used: aripiprazole[16], mirtazapine[17] and lamotrigine/fluoxetine combination[18]. Behavioral therapy as cognitive behavior therapy, covert sensitization and systematic desensitization has been reported useful[19].

In this case, considering that the patient had a partial improvement from fluoxetine treatment but could not continue due to its side effects like akathisia, paroxetine, with less incidence of this side effect and a known effect of reducing impulsive and compulsive behaviors, was preferred and also it is approved to treat generalized anxiety disorder as well. All of reports, patients of this disorder are males as in this case and most of them are adolescents or young adults as our patient. All reports had at least one comorbid psychiatric disorder except one[14], but in these reports no similar comorbidity of anxiety disorder as in our

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patient. Also this case differs from reported cases that it complicated to cause physical injury which is penile erythema and skin abrasions. No trials are available of paroxetine for this disorder which tried in this case and responded well. This case responded well to paroxetine and the use of both supportive psychotherapy and behavioral therapy.

In the management of compulsive masturbation, it is important in order to obtain a recovery, that many interventions be used in a proper way looking at the patient holistically to change not only biological issues but also environmental factors and family dynamics.

There is a need for more studies for this disorder to determine its prevalence and to be classified to suitable category in which there is a phenomenological overlap of features between sexual dysfunctions, impulse control disorders and obsessive compulsive spectrum disorders.

Also there is a need for controlled, randomized clinical trials about the use of SSRIs in the treatment of compulsive masturbation.

## CONCLUSION

I conclude that it is important to find any comorbid psychiatric conditions in which its treatment can help managing compulsive masturbation. Any case of compulsive masturbation should be asked and examined for physical complication due to repeated masturbation which can be serious as in this case.

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