Case report

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A case of excessive sexual drive or satyriasis

W W I P Sandarenu, E U S Erathna, H K K I de Alwis, D R S Adicarum, S C A Arambepola

Abstract

Excessive or abnormal sexual desire in males is called satyriasis. The International Classification of Diseases-10 (ICD-10) describes it under the category of sexual dysfunction, not caused by organic disorder or disease (F 52).

We describe a young male who presented following a suicide attempt in the context of depressive symptoms which were precipitated by marital conflicts due to his increased sexual desire.

Key words: satyriasis, sexual desire, selective serotonin reuptake inhibitors, psychotherapy

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Introduction

Satyriasis or the excessive sexual drive in males is identified as a problem in its own right by the International Classification of Diseases 10th version and is included under the sub-category F52.7 (1). The ICD-11 categorises it as a compulsive sexual behaviour disorder under section 6C72 (2). The term satyriasis originates from Greek mythology which describes a satyr as a half-man, half-horse Sylvan deity who revelled in sexual orgies and had been described as a companion of Dionysus, the Greek god of wine and ecstasy (3).

Several case reports of satyriasis are available from other countries, however, there is a scarcity of such reports from Sri Lanka (4-6).

We report a patient who presented following a suicide attempt in the context of depressive symptoms which were precipitated by marital conflicts due to his increased sexual desire.

Case report

A 25-year-old carpenter who has been married for four years without any children presented to the hospital following a suicide attempt by taking an overdose of haloperidol after a conflict with his wife. He had married at the age of 21 years, after a three-year relationship. During the last two years the couple had been investigated for primary subfertility and all the investigations had been normal. On inquiry, he reported that he was not satisfied following intercourse with his wife and that he desired to have more frequent sexual activity. He reported increased sexual desire and increased frequency of masturbation several times a day for the last ten years duration. He said that he was not distressed by such behaviour and that his sexual desire was satisfied by engaging in frequent masturbation. His frequency of masturbation had recently increased to a level that he engaged in such behaviours even while at work. A couple of months ago, he had sexual intercourse with his wife daily, but this frequency had to be reduced to once in three to four days recently as his wife resisted having sexual intercourse daily. He preferred to stay naked while at home as he wanted to masturbate frequently, and this had led to conflicts with his wife. She had expressed her displeasure with him walking naked around the house and told that she will not tolerate the above behaviours which had resulted in frequent arguments between the couple. Some of these arguments had ended with the patient assaulting his wife. Multiple police complaints had been lodged by his wife regarding his violent behaviour towards her.

He reported depressive symptoms such as persistent sadness, lack of energy and not being able to work in his carpentry shop as earlier for the last three months. In addition, he had sleep disturbances with early morning awakening. He did not have manic/hypomanic or psychotic symptoms. He had self-inflicted a cut injury to his left forearm following a conflict with his wife three months ago. Two days before the current admission, his wife had left him. He was severely distressed about this, and it had led him to take the medication overdose.

He was of heterosexual orientation. He denied sexual relationships with any other person except his wife. He reported watching pornography with heterosexual

content several hours a day since the age of 15 years. Sometimes he was able to achieve sexual gratification by watching pornographic content. There was no history of other sexually deviant behaviours or any history of sexual abuse in the past. His alcohol consumption had increased after his wife left home. However, he did not meet the criteria for dependence. He did not use any other substances including tobacco.

He has consulted a psychiatrist one year ago for his excessive sexual desire, use of pornography and poor anger control and had been prescribed haloperidol and benzhexol. There was no significant past medical or surgical history. There was no history suggestive of hyperactivity or conduct disorder in childhood.

There was a family history of a psychiatric illness in his maternal aunt, however, the exact nature of the diagnosis is not clear.

He was an average student and had completed grade ten at school. After leaving school he had completed a carpentry course. He was an introverted person with a few close friends and was interested in drawing and carpentry.

On examination, he was depressed. His thoughts were preoccupied with ongoing marital conflicts and increased sexual desire. There were no psychotic symptoms including delusions of infidelity.

His physical examination and all basic haematological investigations were normal. We were unable to arrange a hormonal profile or radio-imaging studies due to the COVID -19 pandemic and other restrictions in the country at the time of writing this report.

Our most likely diagnosis of the patient was satyriasis with secondary depression and harmful use of alcohol. We are yet to do his hormonal profile and radio imaging studies to exclude any organic disorder or disease which may have caused the increased sexual desire. His addiction to pornography was considered a part of his compulsive sexual behaviours. He was started on sertraline 50 mg daily and the dose was gradually titrated up to 100mg daily. He engaged in occupational therapy activities during his ward stay and motivational enhancement therapy was initiated for the harmful use of alcohol. He was taught relaxation techniques and anger and impulse control techniques.

Towards the latter part of his ward stay, cognitive behavioural therapy was commenced. Socratic questioning and the downward arrow technique were used to provide insight into his problems and identify deeply seated cognitive errors with the therapeutic goal being a reduction of his compulsive sexual activities. He had low self-esteem and a negative attitude towards himself which were deeply rooted since childhood after being abandoned by both parents in early life. It was identified that these beliefs triggered during stressful situations. The possibility of sexual behaviour as an escape mechanism was also considered. These were discussed during the therapy sessions, and he was helped to identify and correct these cognitive errors. He was also taught distraction techniques for managing his compulsive behaviours in the workplace. We also provided psychoeducation about depression and compulsive behaviours.

He showed improvement in his symptoms with treatment after three weeks, where he was able to significantly control his sexual desires. We did not consider couple therapy as his wife had requested a divorce by that time. During a subsequent clinic visit, he revealed that his frequency of masturbation and the duration of engaging in pornography had reduced significantly and that he was abstinent from alcohol.

Discussion

A multitude of factors have been implicated in the aetiology of hypersexuality and compulsive sexual behaviours including genetic and environmental causes (7). The neural mechanism for sexual addiction is thought to be the same as that for chemical addiction (8). Several neurotransmitters including dopamine and noradrenaline which play major roles in the neural reward pathway are implicated in the pathogenesis of satyriasis (8).

Naguy et al., categorises satyriasis into five subsets to aid treatment decisions (5). These categories are impulsive, compulsive, addictive, emotional dysregulation, and executive dysfunction types (5).

The impulsive subtype has been reported to respond to medications that block the limbic system (potent dopamine D2 receptor blockers such as risperidone) or to medication that enhances the prefrontal control such as stimulants while the compulsive subtype may respond to selective serotonin reuptake inhibitors (SSRIs) or clomipramine (5,9). Naltrexone can be considered in the addictive subtype and the emotional dysregulation subtype may respond to anticonvulsant mood stabilizers (e.g., valproate or topiramate) or beta-adrenergic blockers (e.g., propranolol) (5, 10). The executive dysfunction subtype is associated with a lack of social decorum and poor insight and when in extreme, hormonal therapy had been suggested (5).

Sex Addict Anonymous, based on the model of Alcoholics Anonymous, is a group therapy programme which is available in some Western countries where participants share their experiences and help each other become sexually sober (6, 9). This group therapy has shown some positive outcomes when individual therapy had not been successful (11).

Conclusions

This case highlights the importance of exploring the sexual history of patients presenting to mental health services with symptoms suggestive of other mental illnesses.

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Statement of contribution

WWIPS wrote the case report. WWIPS and EUSE did the literature review and HKKIA, DRSA and SCA supervised. All authors approved the final version of the report.

Conflicts of interest

None declared.

W W I P Sandarenu, E U S Erathna, H K K I de Alwis, D R S Adicarum, S C A Arambepola, Psychiatry Unit, National Hospital, Kandy, Sri Lanka

Corresponding author: WWIP Sandarenu

E-mail: ipsandarenu@gmail.com

http://orcid.org/0000-0002-0167-5558

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