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Mini Review

Traumatic Masturbatory Syndrome: A Proposed Treatment Protocol

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Abstract

This article describes a treatment protocol for TMS (Traumatic Masturbatory Syndrome) an atypical, idiopathic mode of masturbation. TMS is associated with erectile dysfunction and delayed ejaculation. This protocol is designed to be a model for practitioners from a variety of disciplines, perhaps in collaboration with other specialties.

ABBREVIATIONS

TMS: Traumatic Masturbatory Syndrome

INTRODUCTION

Traumatic masturbatory syndrome was described by Sank [1], as a pattern of atypical or idiosyncratic masturbatory style usually in a prone position that appeared to be associated with erectile and orgasmic dysfunction in men. To date there are no peer reviewed data that address the prevalence of this type of masturbation in the general population nor the prevalence of these dysfunctions in those who do practice this style of masturbation. However there is a virtual online community visiting several sites (e.g., healthystrokes.com, Wikipedia) that describes their experiences and struggles with TMS. This has spawned various treatment recommendations from either the site's author(s) or the community at large.

My clinical findings indicate that there are several variables that influence the likelihood of the appearance of this syndrome. These masturbatory variables include *frequency* (times per day or week), *duration* (both number of years of engaging in the style of masturbation and how long the masturbatory session lasts), *amplitude* (intensity of pressure on the penis) and *exclusivity* (whether alternate styles of masturbation or other sexually arousing behaviors are engaged in or if the idiosyncratic style is the sole mechanism for arousal, whether auto erotic or partnered, that lead to reliable erections and orgasm).

TREATMENT MODEL

In the aforementioned article, Sank [1], suggests an overall strategy of resensitizating a desensitized, seemingly deadened organ. My specific treatment model includes a diagnostic evaluation that will include urologic, neurologic and psychological assessment. Psychologically, the diagnostic evaluation would assess the possible presence of an emotional disorder that would preclude a straightforward approach to treating the erectile or orgasmic disorder. Possible emotional disorders could include delusional, ritualistic or disabling mood disorders that might require prior or parallel treatment before or while treating the sexual dysfunction.

Before initiating treatment I require clearance from both a urologic and neurologic perspective, as well as assessing for any sexually adverse medication side effects. Once we have ruled out the presence of a psychological disorder that would require primacy (or at least demand a treatment approach in tandem) I ask that the patient refrain from any prone, excessively strenuous, frequent or abrading masturbation. Many symptomatic men respond knowingly when I refer to their intense masturbatory style as a "death grip". For many this proscription is neither welcomed nor easily achieved. I have yet to find that equivocating on this point of abrupt discontinuation of the old habit leads to a satisfactory outcome. There are those clinicians who ask for complete abstinence from any sexual activity for a specified span of time. I recommend this but recognize that there might be a partner or an important intrapsychic component that sexual activity serves, that would override this recommendation. For example, partnered sex placed on hold might upset an important, perhaps essential, component of the relationship. Or the act of masturbation might stabilize other intrapersonal components of the patient's functioning. For example, masturbation or orgasm might serve as a soporific essential for falling asleep, or they might serve as "self-medication" for a mood disorder, etc. Or masturbation might serve as a bit of sunshine in an otherwise rather dark and anhedonic existence or even relieve boredom. In my assessment as to *why* the patient masturbates, I try to address alternatives to masturbation based on the uncovered reasons (there might be several) for the atypical masturbatory behavior. I collaborate with the patient to discover alternatives to masturbatory behavior during this period of time when I am asking for him to refrain. Some alternatives include meditation and mindfulness [1-3], 2015, and mobile apps such as "Calm" and "Headspace"), relaxation, medication, regular exercise, etc.

On occasion, when there is concern about a partner's reaction to this deferring of sexual activity, I ask to meet with the partner to explain my rationale and work out a plan to satisfy the couple without" breaking training".

Again, with the overarching strategy of resensitization in mind, I believe that a moratorium on any orgasmic release would be optimal. The duration of this moratorium should reflect the patient's self assessment of his libido and, of course, the baseline frequency of masturbation before the onset of treatment. Following this hiatus I ask the patient to begin to self-stimulate with the lightest touch (barely above the threshold of sensation). I sometimes suggest using a feather or the nondominant hand and a lubricant for stimulation while in a supine or seated position. I also encourage exploration of the entire genital area. This would include penile shaft, coronal ridge, head, lateral, dorsal, ventral, frenulum, scrotum, inner thigh and perianal areas. If acceptable to the patient (and partner, if appropriate) I recommend introducing erotica, ever wary that I am not wishing to trigger a compulsive ("look what you made me do, it is the only way I can be aroused now") response. The use of erotca needs to be carefully assessed in the context of any ongoing relationship as well as taking into account the patient's history/proclivity towards excess behaviors (e.g., gambling, alcohol, tobacco and drug use).

Following this module of the reintroduction of light, barely discernible touch in the genital area, I will suggest moving towards a focus on the pleasurable aspects of this experience and the successive approximation of enhancing arousal. Using a mindfulness model, I ask for a shifting of focus from an erection demanding mode to an immersion into a sensuous (general experience by all senses) focus. With repeated practice I suggest moving, at a pace determined by the patient's response, to a sensual (genitally focused) pleasure mode. The use of the dominant hand with lubricants is advised here. Once the patient becomes comfortable with the mindful experience (ever present, non-demanding, almost an erection indifferent mode), I encourage increased attention to those experiences that are erection positive (enhancing the erectile response). Of course all of this stimulation is *not* in a prone position, *not* using intense pressure *nor* abrasion, and not yet intent upon an ejaculatory result. Once attention shifts to the erectile response, I caution against recidivism along the aforementioned dimensions of frequency, duration, amplitude, and exclusivity. The involvement of the partner, if available, can be helpful here to enhance the lessons learned.

This should conclude the intervention. The span of time from onset of treatment to culmination can be widely variable as a reflection of libido, therapist contacts for guidance, results and the too oft variable of noncompliance/recidivism.

DISCUSSION & CONCLUSION

Additional Clinical Finding

I want to address an additional etiological component: In working with men particularly from other cultures and lower economic circumstances, I have found that coarse knit underwear or even the absence of underwear can also lead to similar erectile and orgasmic dysfunction. Assessing for this is yet another area of inquiry for the conscientious history taker. Treatment in these cases, of course, includes the recommendation that the stimulation deadening garments be exiled.

Also, while I have not treated any women whom I have found to have arousal or orgasmic dysfunction related to this syndrome, I nonetheless encourage careful inquiry by practitioners. This line of questioning, too, would address questions of frequency, amplitude, duration and exclusivity that could conceivably deaden the arousal/orgasmic response.

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