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# Fluoxetine-Associated Remission of Ego-Dystonic Male Homosexuality

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*Selective serotonin reuptake inhibitors (SSRIs) have been reported to decrease sexual activity across a broad diagnostic spectrum in men and women. We present a serendipitous finding of fluoxetine-associated suppression of ego-dystonic homosexual activity in a fifty-three year old male for a period of thirteen years thus far. His determination to remain sexually abstinent has been key in his successful treatment.*

**KEY WORDS:** homosexuality; remission; fluoxetine; patient motivation.

## CASE DESCRIPTION

D.M., a 53y/o white male homosexual recovering alcoholic, sober ten years, had engaged in ego-dystonic homosexual activity from his youth. He found his sexual drive controlled on fluoxetine (Prozac) 20 mg, two daily since 1989, which was initially prescribed for dysthymia.

Methylphenidate (Ritalin), started in 1989, 10 mg in the a.m. and noon and 5 mg at 4 p.m., relieved Attention Deficit Disorder, Adult (ADD-A) and buproprion (Wellbutrin) started in 1998, 150 mg qd relieved crippling fatigue and obsessive brooding over slights. Risperidone (Risperdal), also begun in 1998, 0.25-mg q6h prn curbed impulsive angry outbursts over annoyances such as other driver's infractions.

This unemployed professional man sought treatment in our clinic in 1984 for complaint of "depression, anger and irritability." During his childhood his alcoholic father and his mother fought verbally and she battered D.M. and scratched his face he reported.

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He was treated from 1994 to 1999 with lithium 300 mg, 2 bid for history of Bipolar Mood Disorder (BPAD) cyclic. This was ultimately discontinued as no hypomanic or manic symptoms were identified.

He did not want to engage in the active gay lifestyle that he had led and noted that fluoxetine reduced his sex drive, allowing him to avoid homosexual activity. He could still masturbate to orgasm although he usually suppressed this urge to avoid reinforcing his sex drive. He denied sexual addiction symptoms and did not meet criteria for sexual addiction. His sexual dreams were of masturbation rather than sex with another person.

In 1998 he reduced his fluoxetine to 20-mg qod for three weeks but his homosexual thoughts and urges reoccurred, and he restarted it at 20 mg daily. On 10-19-99 fluoxetine was increased to 40 mg daily for recurrence of some depressive symptoms with no loss of sexual function. Due to "crippling fatigue" all his life which he attributed to "allergy or sugar," buproprion 150 mg qd was added resulting in improved esteem and energy and less anger and brooding over perceived or real slights.

## DISCUSSION

Presently, it is unsettled whether nonparaphilic sexual addiction (NPSA) and paraphilia (PA) (1) represent a compulsive spectrum disorder or drive dysregulation syndrome associated with a primary mood disorder (2). Although our patient does not have these disorders it is noteworthy that his undesired sexual activity did respond to a selective serotonin reuptake inhibitor, which we (3) and others have reported in the literature.

Modell (4) (1997) notes that sexual side effects reported during treatment with fluoxetine, paroxetine (Paxil), and sertraline (Zoloft), included decreased thoughts and desire, penile anesthesia, and delayed or inhibited orgasm ranging from 1% to 75%, making them useful in treating paraphilias, sexual obsessions and premature ejaculation.

Kafka (2) (1991) reports that fluoxetine, among other drugs, dampened NPSA and homosexual behavior in three men in a sample of ten male NPSA and paraphilic subjects treated with various medications.

Labbate (5) et al. (1997) found that buproprion 75 mg qd reversed selective serotonin reuptake inhibitor (SSRI) induced sexual dysfunction in four women in a sample of six females and two males. However, the addition of buproprion to our patient's treatment did not interfere with the beneficial fluoxetine effect.

Our homosexual patient's decreased sexual activity on fluoxetine is consistent with the obsessive compulsive disorder (OCD) theory of sexual drive dysregulation which holds that as an OCD spectrum phenomenon the symptom

should respond to SSRI's and not to other classes of antidepressants. However, our patient might have experienced greater control over his sexual activity as he improved from depression, consistent with the idea of sexual drive dysregulation in a primary mood disorder.

We should also entertain the possibility that ongoing distress over his sexual acting out as well as a dampening of sexual intensity with age may play some role in his life style changes though the temporal association of fluoxetine with his greater sexual control is compelling.

His strong motivation to curtail his homosexual activity appears key in his sexual abstinence; we recommend a judicious assessment of an individual's desire to change a preferred sexual orientation before antidepressants or other medications are prescribed for this behavior. A suggestion by the clinician that medication alone may change one's sexual orientation would be perceived as naïve and undermine the patient/doctor relationship.

Our case does not contribute to the resolution of NPSA and PA as a OCD spectrum disorder or sex drive dysregulation in a primary mood disorder but does support a role for fluoxetine in treatment of ego dystonic homosexuality in this patient.

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