Autoerotic Asphyxiation: A Case Report

To the Editor: Self-harm poses a significant safety concern and a challenge to care providers in a long-term care setting, but not all self-injurious behavior necessarily arises from suicidality. Autoerotic asphyxiation is a type of masochistic sexual behavior in which the individual intentionally engages in the practice of achieving sexual arousal related to restriction of oxygen to the brain. While autoerotic death may encompass a myriad of other means of achieving sexual gratification, including asphyxia by plastic bag or inhalation of noxious chemicals, the most common method is by ligature about the neck.[1] All autoerotic asphyxiations are considered accidental and not suicidal and generally result from an individual trying to go beyond the narrow window of safety as a result of erotic efforts.[2,3]

Autoerotic asphyxia has now received its own diagnosis in *DSM-5* under the category sexual masochism disorder with asphyxiophilia.[4] Estimated mortality rate of autoerotic asphyxia annually ranged from 250 to 1,000 deaths in the United States.[5] In the Western countries, the incidence of these deaths is approximately 0.5 per million inhabitants per year.[6] It has been reported that autoerotic deaths occur predominantly in white males.[7] One 9-year retrospective study that reviewed deaths due to autoerotic asphyxia in Kentucky between 1994 and 2001 showed that all victims were white males between the ages of 14 and 59 years.[1] No known specific comorbid mental disorders have been described.

We report a case of a patient admitted to an inpatient psychiatry unit for suspected suicidality who was ultimately able to successfully return to long-term care after responding favorably to a combination of medication, patient education, safety device, and milieu management with behavioral approach.

Case report. Mr A, a 67-year-old man with a known history of schizoaffective disorder and mild intellectual disability was found unconscious in his room at an assisted living facility with a belt around his neck. Prior to this incident, he exhibited compulsive behaviors, such as writing down the same numbers or fixating on drinking Dr Pepper. He also collected boxes of comic books and refused to throw them away. After a stay in the intensive care unit, he regained consciousness, medically stabilized, and was transferred to our inpatient geriatric psychiatric program for attempting to harm himself. However, during his initial evaluation, Mr A explained the reason he had the belt around his neck was that he was choking himself while masturbating because "it feels good." He endorsed neither psychotic symptoms nor depressive symptoms including suicidal ideations, intent, or plan. He was placed on sertraline 50 mg/d with his guardian's permission in addition to his preexisting medication regimen of valproic acid 250 mg BID and quetiapine 100 mg in the morning and 400 mg at bedtime for his chronic psychosis. His sertraline dose was titrated up to 200 mg/d over a 1-month period. In addition to pharmacologic intervention, Mr A underwent a behavioral management program with a team psychologist who offered regular meetings (3 times per week, 20 minutes per meeting) consisting of gradual exposure to potentially unsafe objects under supervision as well as safety education. Mr A was also provided with a specially designed geriatric belt held together with Velcro that cannot be used to create a firm choking hold. Over the course of his stay, Mr A demonstrated significant reduction in compulsive behaviors, and there were no further reported incidents of sexually impulsive acts or asphyxiation episodes during this inpatient treatment, after which he successfully returned to his long-term facility.

Although their behavior is no less concerning than suicidality, patients who intentionally harm themselves for heightened sexual arousal pose unique challenges and require different management approaches. This case presents a man with intellectual disability and schizoaffective disorder who compulsively fixated on things that interested him. This case was similar to the previous case reports,[8] but the difference here was Mr A's clear tendency to compulsively fixate on his other interests.

Previous reports have suggested that autoerotic asphyxiation can be reduced with a combination of haloperidol and sertraline.[9] One case study reports the successful use of lithium in treating life-threatening autoerotic asphyxia.[9] Paraphilic behaviors in association with depressive symptomatology were effectively treated with fluoxetine, imipramine, or lithium in another case series.[10] A successful trial of topiramate and citalopram in combination was reported in the treatment of compulsive-impulsive sexual behaviors.[11]

By treating his compulsive behavior with sertraline, we were able to successfully stabilize the behavior and prevent him from further episodes of self-harm. Our main objective was to create a durable plan that would allow the patient's safe return to assisted living. It was apparent that Mr A valued his independence, and we had to address safety concerns with him, which eventually led to the decision to offer him the specialized geriatric belt as an accommodation that helped facilitate ongoing behavioral compliance.

We would like to suggest that utilization of nonpharmacologic strategies in addition to aggressive treatment using sertraline can help reduce a patient's tendency toward autoerotic asphyxiation. Additionally, more staff education in long-term care settings and public awareness of these unsafe sexual practices may lead to better identification of them.

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