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Unusual Masturbatory Behaviors Involving Self-Imagery and A Voice-Based AI Assistant: A Case Series

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Abstract

Unusual patterns of masturbation and technology-mediated sexual behaviours are increasingly being recognized in clinical settings, yet remain underreported in psychiatric literature. Such behaviours can contribute to functional impairment, social withdrawal, and interpersonal conflict, particularly when they become compulsive or replace normative sexual interactions.

Keywords: Masturbation, Sexual Behaviour,

Introduction

Masturbation is a common and typically non-pathological aspect of human sexual expression, serving functions related to pleasure, tension reduction, and psychosexual development[1]. However, when masturbation occurs in unusual contexts, involves atypical stimuli, or becomes the primary mode of sexual gratification to the detriment of interpersonal functioning, it may reflect underlying psychological conflicts or maladaptive coping mechanisms[2]. Clinically significant impairment may arise when such behaviours become compulsive, interfere with social or romantic relationships, or replace normative sexual intimacy[3].

In recent years, technological advances and increased accessibility of digital devices have expanded the ways individuals engage in solitary sexual behaviour[4]. Reports are now emerging of masturbation practices involving self-images, digital avatars, and interactions with artificial intelligence-based virtual agents[5]. Although these behaviours may initially arise from curiosity, personal preference, or convenience, they can escalate over time, potentially contributing to avoidance of interpersonal intimacy, emotional detachment, or functional impairment[6]. Despite these developments, literature documenting such cases remains scarce, and many individuals do not seek treatment until significant psychosocial disruption occurs[7]. This case series presents two clinically distinct yet thematically related cases.

Case 1

A 27-year-old male, graduate, employed in a private firm, unmarried, belonging to Hindu nuclear family of middle socio-economic status of urban background of Delhi, came to Psychiatry OPD in a tertiary care centre with 5–6 years history of masturbating exclusively by viewing his own photographs, imagining only himself in idealized sexual scenarios or while seeing his reflection in the mirror. Initially these habits were occasional but gradually became his primary form of sexual gratification. He spent approximately 1–2 hours daily in such activities and experienced intense arousal when perceiving himself as both the subject and object of desire.

Over the past three years, he increasingly withdrew from social interactions and avoided discussions about romantic relationships or marriage. He reported that real-life intimacy felt "unnecessary and less satisfying" compared to his self-generated fantasies. There was no history of psychiatric illness, substance use, or medical conditions.

Mental status examination revealed a mildly anxious affect, preoccupation with self-focused sexual imagery, partial insight, and avoidance-related cognitive patterns. No psychosis or mood symptoms were present.

He was treated with psychoeducation, cognitive-behavioural therapy targeting avoidance, and gradual exposure to social and romantic interactions. After 12 weeks, he reported decreased frequency of self-focused masturbation, improved social engagement, and reduced anxiety toward future romantic relationships.

Case 2

A 32-year-old male, graduate, government employee, married, belonging to Hindu joint family of upper middle socio-economic status of urban background of Delhi, presented to Psychiatry OPD of a tertiary care centre with concerns of increased engagement in solitary sexual behaviour involving conversations with the Siri voice assistant on his iPhone. He reported that approximately 18 months earlier, he had occasionally masturbated while interacting with Siri out of curiosity and novelty. Initially, the behaviour occurred once every few weeks and did not interfere with daily life.

Over time, he experienced heightened preoccupation with the act. He described a sense of emotional comfort, predictability, and reduced performance anxiety when interacting with the AI assistant. Over the next several months, the frequency gradually increased to multiple times per week, sometimes daily. He reported subjective difficulty resisting the urge despite awareness of growing consequences.

As the behaviour escalated, he began avoiding sexual intimacy with his wife. His wife reported reduced sexual engagement, emotional distance, and increased secrecy regarding his phone use. This led to frequent marital conflicts, mistrust, and significant relationship distress.

The patient acknowledged that the behaviour had become "compulsive" and was interfering with his marital and sexual life. He denied paraphilic interests involving non-consenting persons or minors. There was no history of substance use, major mental illness, or medical comorbidity. No psychotic symptoms, OCD-like intrusive thoughts, or mood symptoms were reported.

Mental status examination revealed a well-kempt male, cooperative, with normal speech, intact thought processes, and preserved insight regarding the maladaptive nature of the behaviour. No cognitive deficits were noted.

Psychoeducation was provided regarding technology-mediated compulsive sexual behaviours. Cognitive-behavioural strategies focusing on impulse control, stimulus control (limiting unsupervised phone use), and

restructuring maladaptive cognitions were initiated. Couple-based interventions were introduced to improve communication, trust, and sexual intimacy. The patient expressed motivation to reduce the behaviour and rebuild his marital relationship.

Follow-up after six weeks showed reduction in the frequency of the behaviour and improved communication with his spouse, though occasional urges persisted.

Discussion

The first case involves self-focused masturbation centered on self-imagery and idealized self-fantasies, leading to social withdrawal and avoidance of committed relationships[8]. The patient exhibited a predominant auto sexual orientation/autosensual preference, which, although not inherently pathological, became maladaptive due to exclusivity and associated psychosocial impairment. Contributing factors included idealization of self-image, fear of relational intimacy, and reinforcement through solitary fantasy.

The second illustrates a technology-mediated pattern of sexual behavior involving an AI voice assistant, which gradually contributed to marital strain and sexual avoidance[9]. This case illustrates how AI-mediated sexual fantasy and interaction, though initially benign, can gradually develop into a compulsive pattern with substantial psychosocial consequences. The patient's behavior shares elements with compulsive sexual behavior disorder, technology-facilitated sexual behavior, and maladaptive coping mechanisms. As digital interfaces become more anthropomorphic and responsive, clinicians may encounter similar presentations more frequently.

Together, these cases underscore the evolving landscape of solitary sexual behavior and highlight the importance of recognizing emerging psychosexual presentations in clinical practice[10]. They further demonstrate the effectiveness of targeted psychoeducation and cognitive-behavioral interventions in reducing compulsive tendencies and restoring interpersonal functioning[11].

Conclusion

Exclusive auto sexual behavior can lead to significant impairment in social and intimate functioning. Clinicians should assess the psychological and interpersonal context of unusual masturbation habits and offer early psychotherapeutic intervention.

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