CASE REPORT

Hypersexuality In A Rape Victim Child

Nur Amirah Shibraumalisi[1], Mohd Hafidzudin Zainal Abidin[2], Nabil Muhammad Al Kuddoos[3], Abdul Hanif Khan Yusof Khan[4]

[1] Department of Primary Care Medicine, Faculty of Medicine, Universiti Teknologi MARA, Jalan Prima Selayang 7, Batu Caves, 68100, Selangor, Malaysia.
[2] Klinik Kesihatan Merotai Besar, KM 32, Jalan Merotai- Kalabakan, 91000, Tawau, Sabah, Malaysia.
[3] Emergency and Trauma Department, Hospital Selayang, Lebuhraya Selayang- Kepong, 68100, Batu Caves, Selangor, Malaysia.
[4] Department of Neurology, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia, 43400, Serdang, Selangor, Malaysia.

ABSTRACT

Hypersexuality is rare in children. Our case describes a 14-year-old girl who presented with a history suggestive of hypersexuality. She was repeatedly raped and exposed to video pornography at a very young age. Consequently, she became addicted to pleasure during sexual intercourse and actively involved in multiple unprotected sexual intercourses. Management, in this case, was challenging, where early intervention with contraceptive methods and cognitive behavioural therapy were unsuccessful. Subsequently, alternative treatment with Islamic psycho-spiritual therapy combined with conventional therapy resulted in an improvement in her sexual pre-occupation. This case highlights the importance of recognition of hypersexuality, especially among children with a history of sexual abuse as management proofs to be challenging, and requires a multimodal approach to prevent a potentially devastating outcome.

Keywords: Paraphilic disorders, Sexual behaviour, Child, Sexual offences, Psychotherapy

Corresponding Author:
Nur Amirah Shibraumalisi, MMed (Fam Med)
Email: nuramirah9510@uitm.edu.my
Tel: +60136703400

INTRODUCTION

Hypersexuality is defined as a clinical condition characterised by loss of control over urges and behaviours, sexual fantasies, associated with adverse consequences or personal distress (1). However, there are no specific criteria describing hypersexuality in the DSM-V, which limits its applicability. It is a condition with little evidence on its epidemiology, causes, risk factors, definition, diagnostic criteria, and management options. Most of the literature describes hypersexuality among adults, but rarely in children.

CASE REPORT

A 14-year-old girl, accompanied by her mother presented with amenorrhea for six months. Her menses has been irregular, in a two to three monthly cycle since she attained her menarche at the age of 11 years old. Her menstrual flow was usually heavy and prolonged up to 14 days. There was no dysmenorrhea. We were taken aback to find out, her last sexual intercourse was three weeks before the presentation, and it was unprotected.

On further questioning regarding her sexual-social history, it was revealed that she was raped by her uncle on various occasions since the age of five-years-old. Unfortunately, starting at the age of nine years old, she started to indulge in online pornography with her school friends. She started to seek for a sexual encounter at the age of ten years old. Subsequently, her interest in sexual pre-occupation piled up, which made her easily aroused even with visual or physical stimulus towards the opposite gender. Her mind was preoccupied with erotic sexual thoughts multiple times a day. She denied masturbation but would relieve her sexual desires through pornography or unprotected sexual intercourse with multiple partners found through mobile dating applications. Due to multiple sexual engagements, she was involved under police investigation as a victim of statutory rape. Apart from that, she had a low mood for the past two years. However, there were no other symptoms suggestive of major depressive disorder. Her social history revealed, her parents struggle with marital conflicts and she had very limited interaction with her family members. Her academic achievement was below average, and she rarely involved in extracurricular activities in her school. Most of her time was spent chatting via various online social media platforms. She

has no history of consuming cigarettes, alcohol, and substance abuse.

On examination, she was an overweight girl with a BMI of 26kg/m^2 with acanthosis nigricans at her neck. There were no acne and hirsutism. Her blood pressure was 92/62 mmHg with a pulse rate of 65 beats per minute. On mental status examination, she appeared euthymic, mood and affect were appropriate, cognitive function was normal. Systemic examination was unremarkable. Secondary sexual characteristics were appropriate for her age.

Her urine pregnancy test was negative. LH/ FSH ratio was raised (2.2) with a normal serum testosterone level of 0.8 nmol/L. Her prolactin was 181.7 mIU/L (within normal range), and her thyroid function test was normal range. Her fasting blood sugar was 4.5 mmol/L, with an HbA1c of 5.4%. Screening tests for sexually transmitted disease (STD) were negative. Pelvic ultrasound showed features of the polycystic ovarian syndrome (PCOS). Her brain and pituitary magnetic resonance imaging were normal. With the above findings, she fulfilled the Rotterdam criteria; hence we diagnosed her of having PCOS with hypersexuality.

For further management of her PCOS and to regulate her menses, we referred her to a gynaecologist. As she was vulnerable to pregnancy, STDs and sexual abuse, she was started on oral contraceptive pills but was later on changed to intramuscular Depo-Provera due to poor compliance to oral contraceptive pills. Condom usage was advised to prevent STDs. She was referred to a clinical psychologist for the cognitive behavioural therapy and was arranged for child psychiatrist review, but she did not turn up for the appointment because she preferred to be seen by her primary doctor at that moment.

After four months of sessions with primary care physician and psychologist, there was not much improvement in her hypersexuality symptoms. Her parents sought an alternative treatment by sending her to an Islamic psycho-spiritual intervention. After six months of combination therapy, her sexual desires reduced remarkably. She no longer seeks sexual encounters and indulging in online pornography. Moreover, patient's mood improved, and she had a good outlook on her future. Her academic performance and social interactions with her family also got better.

DISCUSSION

The challenging aspect of dealing with a young girl with uncurbed sexual desires was to prevent exposure to sexual abuse, unplanned pregnancies, high-risk pregnancies and STD. To complicate matters, legal implications of hypersexuality in children need to be taken into account as children are minor, and they need to be protected.

Data on the epidemiology of hypersexual disorder in children is scarce due to the rarity of this disorder and lack of agreement on the definition of hypersexuality. However, a prevalence study done among adults in the United States of America revealed that an alarming 10.3% and 7% of man and women respectively have clinically levels of distress and impairment in controlling sexual feelings, urges, and behaviour (2).

Given her history of multiple rapes at a very young age, she is vulnerable to various adverse long term consequences in terms of physical health, mental health, interpersonal functioning and sexual development. A robust evidence display links between sexual abuse and mental illness such as depression, substance abuse, eating disorder, personality disorder, schizophrenic disorders and a higher risk of suicidal behaviour (3). In her case, she is at risk of major depression and other mental health disorder, considering she had a low mood for the past two years.

Maladaptive sexual development is common among sexually abused children, and they are age-specific in characteristics. In a very young child, they might engage in traumatic play and re-enact the experience, while in an older child they are more likely to develop inappropriate sexual behaviours such as sexual pre-occupation, sexual aversion or sexual ambivalence (3). As displayed in this case, the child has sexual pre-occupation indicated by excessive pornography consumption, extreme thoughts about sex, easily aroused, permissive attitude towards sexual invitation and voluntary multiple unprotected sexual intercourses.

Hypersexuality can be a result of organic causes; hence it is vital to rule out medical conditions which could potentially be reversible. Conditions that should be considered are brain pathology or brain injury, endocrine abnormalities such as pituitary dysfunction, hypergonadism and substance abuse. Furthermore, substance abuse need to be considered for example abuse of alcohol, amphetamines, cocaine, and marijuana. Psychiatric ailment e.g. bipolar disorder, post traumatic stress, borderline personality and obsessive compulsive disorder need to be assessed when there is no evidence of medical causes. Of this case, she has no suggestive features of organic causes, and she did not fulfil any psychiatric disorders mentioned above.

Among pharmacotherapy that has been used to treat hypersexuality are selective serotonin reuptake inhibitor (SSRI), noradrenergic serotonergic reuptake inhibitor (NSRI), antiandrogens, luteinising hormone-releasing hormone (LHRH), opiate agonist and mood stabilisers such as lithium and depakote (4). However, most research on pharmacotherapy in treating hypersexuality had methodological flaws, and these studies were

done among white adult men (4). Nevertheless, pharmacotherapy should be considered as an adjunct, given its possible benefits to improve the sexual urge and reduce the risk of unwanted sequelae of hypersexuality.

The management of a child with hypersexuality requires a multi-dimensional approach. The most common approach of hypersexuality is through cognitive behavioural treatment (CBT) and psychodynamic psychotherapy. CBT aims at reshaping mental distortion on sexual behaviour while psychodynamic therapy explores core conflicts that originate the sexual expressions. In recent years, many studies suggest incorporating the aspects of spirituality in the holistic approach of a patient, especially in palliative care and mental health patients. As presented in this case, the patient's mother resorted to psycho-spiritual treatment approach when her condition did not improve with the conventional psychotherapy. Accumulating evidence reveals that psycho-spiritual therapy is beneficial in managing mental disorder such as anxiety, depression, bereavement, post-traumatic stress and obsessive-compulsive disorder (5). However, specific to sexual addiction, the evidence is scarce. A closer comparison would be a case report of a patient who successfully overcame his drug addiction through psycho-spiritual intervention as an adjunct to methadone replacement therapy (5). Religion and spirituality are theorised to add positive attitude and empowers the mind of the believer to become a better person, and that will hopefully aid them to overcome their illness.

CONCLUSION

Hypersexuality among children is rare. Our case depicts sexual maldevelopment as a consequence of sexual abuse from young. Poor social support, coupled with her parents' marital conflicts, might have contributed to her low mood and hypersexuality. The management is very challenging with limited high-quality research available supporting the efficacies of pharmacotherapy and psychotherapy, especially in children. This case represents promising results of the psycho-spiritual intervention in combination with conventional psychotherapy which could be considered when managing hypersexuality in children. More studies are required as the research of hypersexuality in children is still lacking and need urgent attention.

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