Case Report

Nymphomania Associated With Childhood Sexual Abuse: A Case Report

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Abstract
Defining and classifying nymphomania has been a challenge for clinicians. It is characterized by an unquenchable urge to engage in repeated sexual contact with many partners without a deep emotional involvement. The sexual drive is unvarying, voracious, impetuous, and unrestrained. The case report describes a young female who presented with increased sexual desires and engaging in excessive sexual activity leading to divorce and marital disharmony in her second marriage. There was a history of childhood sexual abuse. Women developed nymphomania out of engagement in the behavior due to a genetic predisposition or from an environmental stressor such as trauma or sexual abuse. Since sex addiction is not a recognized disorder in DSM-5 or ICD-11, women who have this disorder have difficulty receiving treatment. Proper diagnosis and treatment of such patients will lead to better functioning and quality of life.

Keywords
Sex addiction, nymphomania, hypersexual disorder, compulsive sexual behavior, child sexual abuse

Received 26 December 2019; revised 1 February 2021; accepted 3 April 2021

Introduction
Before the nineteenth century, promiscuous women were mainly treated as delinquents, not medical cases, but this changed after the institutionalization of such cases in insane asylums.¹ The nineteenth century saw a shift from describing women being overwhelmed by excessive sexual desire using the term “furor uterinus” to “nymphomania.”² Esquirol³ taught that, “Erotomania is to nymphomania what the ardent affections of the heart when chaste and honourable are in comparison with frightful libertinism; while proposals most obscene and actions most shameful and humiliating betray nymphomania.” Bianchi described three forms of erotic hysteria: Erotic paranoia—in which a delusional jealous woman endlessly wishes to copulate with her partner so as to render him unable to make love to the woman she imagines are always after him; Platonic dreamers of love—women of approximately 50 years of age who pursue men with love letters and flowers, but refuse copulation; and Nymphomania—“women with unfulfilled sexual craving that is intense and ardent.”⁴ In the 1940s, labels such as nymphomania, erotomania, Casanova, and Don Juan Syndrome were used to conceptualize excessive sexual behavior as an immoral or antisocial act.⁵ Nymphomania was defined by Auerbach as: “the insatiable impulse to engage in an abnormal number of sexual contacts with an abnormal number of partners without a deep emotional involvement. The sexual drive is unvarying, voracious, impetuous, and unrestrained. The partner is merely the vehicle or the object rather than the participating companion.”⁶ Sexual addiction is similarly marked by an uncontrollable engagement in sexual activity, causing distress and impairment to the person’s life, and severe stress on the family, friends, and work environment.⁷ Despite the negative consequences, the subject persists in engaging in the activity.

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It is not an uncommon condition. A US study estimated its prevalence to be 3% to 6% of the population. The prevalence of subclinical forms of this condition is much higher (13% of men and 7% of women). Guigliamo states that once a person physiologically changed, the subject eventually depends on the sexual orgasm to regulate emotions. Empirical research has demonstrated that individuals “can develop maladaptive patterns of consuming substances and behaviours that are essential for survival, including food and sex.” Women develop nymphomania out of engagement in the behavior due to a genetic predisposition or from an environmental stressor such as trauma or sexual abuse, family factors, and exposure to “cybersex.”

Treatments for nymphomania include psychotherapy and medication such as antidepressants, antipsychotics, and medications for other compulsive behaviors. Since sex addiction is not recognized, and therefore neither is nymphomania, women who may meet the criteria for this disorder are in an unpleasant spot to receive treatment. We report a case of nymphomania associated with childhood sexual abuse.

**Case Report**

A 23-year-old female, educated up to 6th class, resident of Nepal, married since 4 years, having 2 children was brought by her husband with chief complaints of increased sexual desire since the past 8 months. Patient was apparently all right about 8 months back when she started having excessive thoughts and desire of having sex. She would have sexual relations with her husband 2 to 3 times daily. She would feel like having sex with any man that she would see if the circumstances permitted it. Her husband had caught her engaging in sexual acts with multiple males from the neighborhood and some who the patient barely knew. The patient would not use any form of protection during the acts. She did have distress from these thoughts and would regret her acts as she knew that they were wrong. However, she said that she was unable to control these urges, though if the circumstances did not permit she would not do it. The husband reported that these acts occurred in increasing frequency of 5 to 7 days after her menstrual bleeding. The patient reports some uncomfortable feeling in her lower abdominal region during this time. She had never taken medicines for the above complaints. No history of features suggestive of depression or anxiety.

No history suggestive of intellectual disability, epilepsy, head injury, neuroinfectious disease, or substance abuse. No past history of any mental or physical disorder. She had a strict upbringing. She denied any substance abuse.

She came to know about sex from friends. Her first sexual experience was with a cousin who forced her to have sex at the age of 14 years. She had not resisted as she liked him, though she was very fearful and had not enjoyed the experience. However, this clandestine relationship continued till she was at the village. She was first married at 16 years of age for 6 months but marriage ended due to her husband discovering her extramarital relationship. After her separation, she continued to have sex with her cousin and few of his friends. She was married again at the age of 18 years but she continued to remain at home as her husband was working out of India. He used to visit for 2 to 3 months in a year when she would mostly avoid sex with others with difficulty, though she did admit that on few occasions on some pretext she left home to meet her cousin or others. Patient has two children. About 8 months back, she accompanied her husband to this city. She tried her best to have frequent sex with her husband to avoid relations with others. But when her husband went for duty, she was not able to control her desire and began having sexual relations with neighbors or even strangers. Once her husband had caught her in the act, but even after that she did not stop. Despite all this, her relations with her husband are cordial and he insisted on seeing a psychiatrist for the problems.

Her menses were regular with the last menstrual period 20 days back. Her general and systemic examination was normal. On a mental status examination, she was kempt, clean, appropriately dressed, and in touch with reality. Her attitude toward the examiner was cooperative. Her rate, tone, volume, and rhythm of speech were normal. Her speech was guarded, coherent, and relevant. She said that she was not able to control her sexual urges and she did gain pleasure from them. Mood was euthymic. Her affect was adequate and appropriate. There were no formal thought disorders, no delusions/suicidal ideations, and no hallucinations/illusions/derealization/derealization. Her cognitive functions were normal. Insight was unimpaired. On the PATHOS questionnaire for sexual addiction, her score was 4 which was higher than the cut-off score of 3. On the Bergen-Yale Sex Addiction Scale (BYSAS), her score was 18. Four of the six BYSAS items were endorsed as “often” or “very often” fulfilling the criteria for sexual addiction. Patient was started on cognitive behavior therapy and fluoxetine 20 mg daily. However, she was lost to follow-up as her husband took her back to the village.

**Discussion**

The above case describes a young female with increased sexual desires pointing toward nymphomania. The etiology of the condition varies. If marked increases in libido coexist with the other elements, the clinician should first give careful consideration to the sources of the libido excesses. The possibility of a major psychotic process or depression is supreme. Frontal lobe lesions, brain injuries, epilepsy, dementia, and Parkinson’s disease may be associated with hypersexuality. The reported case denied any symptoms indicating organicity or psychosis.

Three models have been proposed to explain hypersexual disorder. Sexual dysregulation model theorizes that
hypersexuality results from sexual abuse in childhood or experiences that shape future sexual behavior as seen in our patient. Sexual addiction and dependency model explains the condition as a brain disease due to which the subject is not able to control her urges, thoughts, and behavior as it relates to sex. The sexual compulsivity and impulsivity model explains the increased sexual desire and activity as a mode of coping with depression or anxiety.\textsuperscript{18} Nymphomania also has similarities with substance use disorders, including an early onset with a chronic-relapsing course that comprises pursuit of short-term reward (i.e., orgasm in hypersexual disorder or a “high” in substance use disorders), despite potential long-term negative consequences, and frustrated attempts to inhibit or control the behavior.\textsuperscript{19}

The neurotransmitters dopamine and serotonin are implicated in this disorder while endorphins and androgenic hormones seem to have a critical role.\textsuperscript{13,18} A diffusion tensor imaging study observed that affected individuals had significantly higher superior frontal region mean diffusivity than controls, which correlated with symptom severity. In addition, in a go-no-go task patients with hypersexual disorder obtained higher impulsivity scores than control subjects.\textsuperscript{20} Affected subjects have emotional regulation deficits, cognitive rigidity, and poor judgment.\textsuperscript{21} Hypersexuality is a rare side effect of dopamine agonists in Parkinson’s disease patients implying that nymphomania may be associated with dopamine pathway dysfunction.\textsuperscript{22} Frontal lobe involvement, dopamine pathway dysfunction, increased impulsivity, poor emotional regulation, cognitive rigidity, and poor judgment support the association of hypersexual disorder and behavioral addiction.

Although it may not be possible to discern the cause, careful diagnosis and reasonable treatment may lead to the return of self-control and normal libido. One study observed that 63\% of women with nymphomania had suffered childhood sexual abuse.\textsuperscript{15} Similar findings were reported by few other studies.\textsuperscript{13,23-25} A study found a correlation between sexual compulsivity and childhood emotional abuse but not with childhood sexual abuse.\textsuperscript{26} This result may be explained by taking into consideration the discipline model.\textsuperscript{24} It may be that childhood sexual abuse is the environmental stressor; yet the onset of nymphomania may arise due to the lack of a supportive environment after the traumatic event.

In agreement with earlier work, this case report suggests that nymphomania or hypersexual disorder can exist as an independent disorder and may not always be considered as associated with another psychiatric disorder. This issue in the Indian subcontinent context especially hypersexuality in a female is considered a taboo and not clearly understood which leads to difficulties in seeking treatment. Moreover, lack of clear treatment guidelines make it difficult for the clinician to manage such cases. Hence, finding out a proper cause, diagnosis, and subsequent treatment will lead to better functioning and quality of life in such patients.

**Declaration of Conflicting Interests**

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The authors received no financial support for the research, authorship, and/or publication of this article.

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