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Zoophilia and hypersexuality in an adult male with schizophrenia: A case report

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ABSTRACT

Background: Paraphilias can be seen in the context of schizophrenia. Among the paraphilias, zoophilia is less commonly reported. Paraphilias are often associated with hypersexuality and psychiatric comorbidities. Paraphilias like zoophilia may result in development of sexually transmitted diseases.

Method: After obtaining informed consent, details of history were obtained. Mental status of the patient was done at regular intervals. General physical examination, appropriate blood investigations and neuroimaging were done.

Result: We have described here the case of an adult male suffering from schizophrenia with co-morbid alcohol and cannabis use disorder with hypersexuality, who had zoophilia and developed hepatitis B infection.

Conclusion: Paraphilias like zoophilia can lead to development of sexually transmitted disease in patients with schizophrenia.

1. Introduction

Schizophrenia is a severe mental disorder. Altered sexual behaviour may be seen more frequently in patients with schizophrenia. Zoophilia (Bestiality) is a form of sexual perversion (paraphilia), which involves sexual fantasies and acts with animals. Paraphilias are included under psychiatric disorders and this terminology was used for the first time in DSM III (First, 2014). DSM 5 uses the term paraphilic disorder instead of paraphilia and has placed zoophilia under "other specified paraphilic disorder" (American Psychiatric Association, 2013). ICD -10, describes paraphilias as disorders of sexual preference (ICD – 10 code F65) (World Health Organization, 1992).

The exact prevalence of paraphilias are not known (Seto, Kingston, & Bourget, 2014). Evidences support that multiple paraphilic disorders can co-exist together. Also, hypersexuality is commonly reported in patients with paraphilic disorder. Paraphilias are commonly seen in association with mood disorders, attention deficit hyperkinetic disorder, anxiety disorders and substance use disorders (Seto et al., 2014). Sometimes paraphilia presents as an early sign of psychosis (Lesandrić, Orlović, Peitl, & Karlović, 2017). In a study, it was found that 36% females and 71% of males suffering from schizophrenia have at least one disorder of sexual preference (Kokoszka, El Aal, Jodko, & Kwiatkowska, 2010). The most common forms of paraphilia among psychiatric inpatients are – voyeurism, exhibitionism and sexual masochism (Marsh et al., 2010). Zoophilia is a relatively uncommon form of paraphilia. Earlier reports suggest the prevalence of zoophilia to be significantly higher among psychiatric inpatients than those in medical inpatients (Alvarez & Freinhar, 1991). Presence of comorbid paraphilia in schizophrenia is associated with increased rate of suicides as well as longer duration of hospitalization (Marsh et al., 2010). This case report aims to present one such unusual case of grossly inappropriate sexual behaviour (hypersexuality and zoophilia) in a patient with chronic schizophrenia.

2. Case history

Mr Mahesh (name changed) is a 35 year old man of Indian origin. Mr. Mahesh was brought to the psychiatric facility for consultation with the complaints of gross disorganization and inappropriate behaviour not keeping with the social norms and standards for past four years.

Mr Mahesh was seemed to be well-adjusted to his personal, social, marital and occupational life some 4 years ago. He had healthy interactions with his family and neighbours. Like any other 'normal' human, he too followed a daily schedule and had a good social standing. He had healthy relations with his wife too, even on the sexual front. With the beginning of illness, his behaviour had started to change in the form of oddities. He started neglecting his self -care and personal hygiene. People around the neighbourhood, and the family members had started noticing inappropriate smiling and talking to self, most of the times. His sleep was reduced significantly (2–3 hours per day). He would wander

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aimlessly in and around the village. Most of the times, he would remain withdrawn to self (not showing any emotional concern to any events or persons, marked reduced social interaction, paucity of speech, decreased expression of needs). Family members also reported disorganized behaviour in the patient as evidenced by collecting garbage and keeping it in his pockets. It was also reported that he would talk irrelevantly most of the time during the course of his illness. Due to marked irrelevancy in speech, he was not comprehensible. At times, he was found to consume country made liquor or cannabis in the form of *ganja*. Due to which, on several occasions, for a few days, he was often kept under close supervision at home by the family members. There is also history suggestive of regular use of tobacco in chewable form (six to ten times per day) for more than 10 years in the past.

During this period, his wife had observed that he would ask to have intercourse with her too often (multiple times in a day). Before the illness, they would consummate once in a week or so, he would now demand having sexual intercourse with his wife every day. He would ask to have intercourse in broad daylight as well, with all the family members around. His wife too caved in to his demands for quite some time in the beginning but on refusal, she was met with anger and irritability. As the illness progressed, his demands for sexual intercourse increased further to an extent that he would even make such demands in front of his children or when his wife would be occupied in household chores.

The patient started to make inappropriate gestures and sexually coloured remarks for other women as well. The patient also expressed desires to have sexual intercourse with his sister-in- law and other female relatives. The patient had also indulged in reading erotic magazines and books throughout the day. There was increase in frequency (several times every day) of masturbation as well. Sometimes, he would even masturbate in public, for which he would be scolded.

Over the past two years, the patient had also started to make sexual contacts with lower animals as well. He would often have intercourse with the calves in his village. He would customarily go out into the nearby forest where the cattle would graze and was even caught red handed by the village people while indulging in such acts. Due to persistent refusal by his wife for sexual intercourse over past two years, his predominant sexual contact during this time was with animals. He claimed that he enjoyed having intercourse with animals. During this period, he fantasized about animals during masturbation. These inappropriate sexual behaviours were reported, irrespective of substance consumption.

The patient was hospitalized. General physical examination including examination of the genitalia was done. Routine haematological investigations, thyroid function test, liver function test, kidney function test, test for syphilis (VDRL) and HIV (ELISA) were insignificant; however he was found positive for hepatitis B. Neuroimaging had revealed mild diffuse cerebral atrophy (in CT scan). On mental status examination, inappropriate affect, incoherent speech and disinhibited behaviour was found. He was diagnosed with undifferentiated schizophrenia with harmful use of alcohol and cannabis with tobacco dependence with excessive sexual drive with other disorders of sexual preference (zoophilia) as per the ICD -10 diagnostic criteria. He was treated with olanzapine up to 20 mg/day and lorazepam 4 mg/day for a period of four weeks. Due to non-response and persistent agitation, later electroconvulsive therapy (ECT) was given. After three ECTs, the patient had multiple episodes of generalized tonic clonic seizures. Electroconvulsive therapy was stopped and neurology opinion was sought. He was started with valproate 1000 mg/day for seizure. Risperidone was started due to non-response to olanzapine, to which he had shown response (at a dose of 8 mg/day with trihexyphenidyl 4 mg/day). At the time of discharge, his inappropriate affect, incoherent speech, disorganized behaviour, hypersexuality had reduced significantly. He was maintained well till four weeks follow up.

3. Discussion

Zoophilia (bestiality) is an understudied entity. It is often poorly reported. The major reason for under reporting is – the victim of abuse in zoophilia are animals, who cannot report a complaint. As the victim involves non-human subjects, it is not given due importance in society. Many myths related to “sex with animals” (for example: intercourse with animals can cure certain illnesses) prevail in the society; hence it is very often ignored. Zoophilia (bestiality) is considered as a punishable offence in most of the countries across the globe including India (Holoyda & Newman, 2014; Reddy & Murty, 2014). People indulging in zoophilic activities are more likely to commit other sexual offences. People who have sex with animals often perceive the quality of sexual relationship with animals to be superior than human sexual contact and have a tendency to show interest in choosing animals for long term relationships (Sendler, 2019). Our patient has multiple disorders of sexual preferences (zoophilia and exhibitionism); however zoophilia was significant and exhibitionism (masturbating in public) was less frequent, hence not considered in diagnosis. Schizophrenia, substance use (cannabis and alcohol) and hypersexuality were the risk factor for development of zoophilia in our case.

The diagnosis of undifferentiated schizophrenia was made on the basis of presence of negative symptoms and disorganization in thinking and behaviour. Substance (cannabis) induced psychosis and schizoaffective disorder can be other differential diagnosis in our case.

Sometimes, subnormal intelligence may be associated with such behaviour. In our case, formal assessment of intelligence and psychometric assessment were not possible due to uncooperativeness of the patient. However, there was no feature suggestive of mental retardation as the patient had no history of developmental delay and he was fully functional prior to the onset of his illness (four years back).

There is no specific treatment for zoophilia. Treatment of zoophilia is often a challenge for the clinicians (Miletski, 2001). Various pharmacological as well as non-pharmacological strategies have been tried for the treatment of paraphilias. The pharmacological agents basically target hormonal receptors (oxytocin, prolactin, testosterone, estrogens, leuteinizing hormones, follicular stimulating hormone) or serotonin-dopamine-norepinephrine receptors (Guay, 2009).

Unprotected sexual contact with animals increases the risk of acquiring sexually transmitted diseases and rare zoonotic diseases, which can be further transmitted to other individuals in the society through sexual contact. Our patient was found positive for hepatitis B. The hypersexual behaviour leading to unprotected sexual contacts and zoophilia might be responsible for contracting hepatitis B infection. He had regular sexual contacts with his wife and there was no use of barrier contraception, which had further increased the risk of transmission of sexually transmissible diseases. During current evaluation, patient’s wife was found negative for sexually transmitted diseases and was advised to use barrier contraception to prevent transmission of sexually transmitted diseases. Often the reports of people involved in zoophilic activities are done in the forensic point of view. As it is rarely discussed, despite being considered as a mental disorder, its management has not received due attention. Often, it remains undiagnosed and untreated (Marsh et al., 2010). The clinician needs to evaluate the sexual behaviour and preferences of patients with psychiatric disorders in order to prevent development and transmission of sexually transmitted diseases.

Conflict of interest

None.

Ethical statement

Informed consent has been obtained from patient’s caregiver.

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