CASE REPORT

Somnophilia and Necrophilia in a Woman with Persistent Depressive Disorder and Congenital Amniotic Band Syndrome: A Case Report

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ABSTRACT

Paraphilic disorders involved persistent, intense, sexually arousing fantasies or behaviors towards non-human objects, the suffering or humiliation of oneself or others, or non-consenting individuals, which persist for at least six months and result in significant distress in functioning. Among the rarer paraphilic interests are necrophilia and somnophilia, increasingly conceptualized under the term "passivity paraphilias." While SSRIs are considered first-line pharmacotherapy, many cases exhibit incomplete response, necessitating adjunctive options. Topiramate, an anticonvulsant with known effects on impulse control, has shown emerging promise in treating paraphilic symptoms. Here, we present a case emphasising the therapeutic role of topiramate in a woman with paraphilic interests, persistent depressive disorder, and congenital amniotic band syndrome.

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INTRODUCTION

Paraphilic disorders are characterised by persistent, intense, sexually arousing fantasies or behaviours that typically involve non-human objects, the suffering or humiliation of oneself or others, or non-consenting individuals, including children, which persist for at least six months and result in significant distress or impairment in functioning (1, 2). While more widely recognised variants include voyeurism and exhibitionism, rarer expressions such as somnophilia (sexual arousal toward sleeping individuals) and necrophilia (arousal toward corpses) are far less understood and underreported. These are often grouped under the umbrella term "passivity paraphilias" due to their shared focus on unresponsive or incapacitated subjects (3, 4).

We present a case involving a patient with a paraphilic disorder and a history of congenital amniotic band syndrome (ABS), a rare condition with an estimated prevalence of 0.7 per 10,000 live births) (5). This case emphasizes the complex relationship between adverse childhood experiences, chronic disability, and the development of paraphilia, highlighting how early traumatic events can contribute to the emergence of such disorders. Additionally, it supports the therapeutic potential of topiramate, offering evidence for its role in mitigating symptoms and improving outcomes.

CASE REPORT

A 27-year-old woman with a medical history of congenital constriction band syndrome and congenital limb deformities presented with a four-year history of persistent low mood, which had progressively worsened over the past two years. Her depressive symptoms began following multiple surgical interventions and frequent hospital admissions. Despite no significant changes in

her appetite, she experienced a weight gain of over 10 kg within six months, which was likely attributed to the administration of steroid injections for the management of chronic pain. The patient's depressive symptoms preceded and persisted independently of intermittent high-dose steroid use, with no Cushingoid features and mood fluctuations unrelated to steroid cycles. Her fatigue progressively intensified, often resulting in emotional distress and tearfulness by the end of the day. She described feelings of hopelessness and guilt, which she perceived as a significant burden to her family. Although passive suicidal ideation was reported, she denied any active plans or prior suicide attempts. She denied any associated anxiety, manic or psychotic symptoms with the mood changes.

She reported distressing sexual fantasies and arousal triggered by images or real-life encounters with sleeping, intubated, or deceased individuals, as well as animals. These experiences were often accompanied by pain originating from a constriction band near the genital area. The constriction band affected the perineal soft tissue near the genital area without anatomical or functional compromise, though the patient reported recurrent genital pain, intensified during arousal.

Although the patient experienced intense arousal upon seeing sleeping or deceased individuals, she denied ever approaching any corpse or sleeping person. Her urges remained confined to mental fantasies and solitary masturbation as a means of symptom relief. Masturbation frequency increased progressively from two to three times per week to up to two to three times daily at its peak. The patient's sexual fantasies were predominantly somnophilic and necrophilic in nature, devoid of typical heterosexual imagery. Masturbation was typically triggered by the sudden onset of genital pain associated with arousal from passive imagery and performed as a coping strategy for both physical discomfort and intrusive urges. However, this led to significant religious guilt. These fantasies intensified over time but remained non-coital and ego-dystonic.

During early childhood at the age of 7, the patient experienced orgasm-like sensations characterised by genital warmth, tachycardia, and euphoria during non-coital physical proximity to sleeping family members, which she usually rubbed her grandmother's hands as she was asleep. Retrospectively, she identified these sensations as similar to later orgasmic experiences.

During adolescence, she experienced somnophilic urges for the first time after seeing a photograph of a sleeping person. Around the same period, her first exposure to pornographic material occurred during adolescence through a peer's recommendation. She recalled that the material depicted consensual heterosexual acts and was not paraphilic in nature. Subsequent avoidance was driven by guilt and religious conflict. She never engaged in sexual activity with others and identified as heterosexual. There was no history of sexual abuse or incest. Early childhood experiences included isolated incidents of sexualised sensations during non-coital contact with family members, which the patient later retrospectively identified as orgasm-like, but no evidence of sexual abuse was found. The patient had no history of steady sexual relationships. She identified as heterosexual but maintained only two brief adolescent romantic relationships, neither of which involved sexual activity. Formal cognitive assessment revealed no intellectual disability or neurodevelopmental disorder. The patient displayed average intelligence and appropriate social skills throughout psychiatric evaluations.

She had undergone multiple surgeries and long-term pain management, including high-dose opioids and anticonvulsants. Chronic pain, visible deformity, and early rejection by her biological father contributed to feelings of worthlessness. She was primarily raised by her mother and maternal grandparents. The death of her grandfather at age seven, who was her primary attachment figure, was a profound emotional loss and marked the onset of her somnophilic fantasies.

Despite partial improvement with SSRIs (duloxetine and sertraline) and antipsychotics (risperidone and quetiapine), adjunctive topiramate demonstrated superior benefit in reducing paraphilic urges and associated distress. Antipsychotic use was tapered due to sedation. The combination of topiramate with sertraline provided additive benefits, likely due to topiramate's anti-impulsivity properties complementing SSRI-mediated libido modulation. Topiramate (150 mg daily) was added, leading to reduced sexual preoccupations, better impulse control, and incidental benefits including weight loss and pain reduction.

Psychotherapy continued, focusing on cognitive restructuring and spiritual coping. Given her strong religious background, spiritual integration proved important. Despite initial guilt, she found strength in religious rituals, self-compassion, and a belief in divine purpose.

DISCUSSION

Paraphilic disorder is diagnosed when a person experiences intense, recurring sexual urges or fantasies involving unusual targets or behaviours that cause significant distress or problems in relationships. Unlike general hypersexuality, which may involve excessive sexual thoughts or actions, paraphilic disorders focus on atypical interests and are considered clinically relevant when they interfere with daily functioning (1).

Among the less commonly discussed paraphilic disorders are necrophilia (sexual attraction to corpses) and

somnophilia (sexual attraction to sleeping individuals), both of which remain under-researched despite their clinical and forensic significance. Some scholars have proposed grouping these under the term "passivity paraphilias," given their shared theme of sexual arousal directed towards unresponsive, non-consenting subjects (3). These paraphilias intersect with issues of power and control, reflecting a dynamic of domination and subjugation. This commonality highlights a deeper psychological pattern wherein sexual gratification is linked to control over a passive or incapacitated partner (4). Furthermore, sleep and death lie on a behavioural continuum, both marked by reduced responsiveness and voluntary control. While sleep is reversible and death is permanent, both states involve complete defenselessness, which may be exploited by individuals with such paraphilic tendencies (3).

Our patient's symptoms emerged during the latency phase of psychosexual development, shortly after the death of her grandfather. This loss likely disrupted attachment security and contributed to arousal patterns linked to stillness and silence. Her fantasies, while non-coital, were deeply distressing and symbolic.

ABS contributed to both physical and emotional vulnerability. A prior report similarly described a woman with untreated ABS and persistent depressive disorder, suggesting that chronic illness, especially when poorly managed, can leave lasting psychological sequelae. In our patient, repeated hospitalisations and bodily pain likely reinforced internalised feelings of defectiveness and difference, contributing to mood disturbances and sexual preoccupations (5).

Based on existing literature, the pharmacological management of paraphilic disorders remains heterogeneous and uncertain (2). Although the neurobiology of sexual behaviour is not yet fully understood, emerging evidence has identified key roles for specific neuronal circuits and neurotransmitter systems (particularly the serotonergic system) in the pathophysiology of paraphilic disorders and hypersexuality (1). In this case, the patient was treated with sertraline, in line with current evidence supporting SSRIs as a first-line option for reducing the intensity and frequency of paraphilic urges. SSRIs not only modulate mood but also exert anti-libidinal and anti-obsessional effects, making them particularly suitable for managing ego-dystonic sexual preoccupations (2). These findings reinforce the importance of tailoring pharmacological interventions to both the neurobiological underpinnings and the individual's clinical risk profile.

In addition to an SSRI, the patient was treated with topiramate. Though primarily licensed for seizure disorders, topiramate has demonstrated efficacy in managing impulsive behaviours such as alcohol dependence, binge eating, and kleptomania. While no clinical trials have yet confirmed its effectiveness in treating paraphilic disorders, several case reports suggest that it may reduce unwanted sexual urges and hypersexuality at doses of 50–200 mg, with effects typically observed within 2 to 6 weeks (1). Topiramate is believed to modulate impulsivity and hypersexuality through its GABA-ergic agonism and glutamatergic antagonism. By enhancing inhibitory neurotransmission and reducing excitatory pathways, it dampens hyperarousal and intrusive sexual preoccupations. In one case involving fetishism, topiramate led to improved impulse control following unsuccessful psychotherapy, with no reported adverse effects (2). Its use in this patient reflects its potential as an off-label pharmacological option for paraphilic symptoms.

CONCLUSION

This case illustrates how early trauma, chronic disability, and psychosocial adversity can culminate in distressing, ego-dystonic paraphilic symptoms. The patient's necrophilic and somnophilic fantasies were shaped by grief, pain, and attachment disruptions. Her experience underscores the psychological complexity of passivity paraphilias, particularly when layered with disability and cultural guilt.

Treatment combining SSRIs, adjunctive topiramate, and psychotherapy yielded meaningful improvements. Her response highlights topiramate's potential role in managing paraphilic urges, especially in refractory cases. This case advocates for a compassionate, multi-dimensional approach to psychosexual disturbances in psychiatric practice.

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