Chapter Sex: Paraphilic Disorders: Clinical Descriptions

If you are like most people, your sexual interest is directed to other physically mature adults (or late adolescents), all of whom are capable of freely offering or withholding their consent. But what if you are sexually attracted to something or somebody other than another adult, such as animals (particularly horses and dogs; Williams & Weinberg, 2003) or a vacuum cleaner? (Yes, it does happen!) Or what if your only means of obtaining sexual satisfaction is to commit a brutal murder? Such patterns of sexual arousal and countless others exist in a large number of individuals, causing untold human suffering both for them and, if their behavior involves other people, for their victims. These disorders of sexual arousal, if they cause distress or impairment to the individual, or cause personal harm, or the risk of harm to others are called paraphilic disorders. It is important to note that DSM-5 does not consider a paraphilia a disorder unless it is associated with distress and impairment or harm or the threat of harm to others. Thus, unusual patterns of sexual attraction are not considered to be sufficient to meet criteria for a disorder.

There are many harmless aberrations, such as some fetishistic arousal patterns (see next section), which harm no one, are not distressful or impairing, and therefore do not meet criteria for a disorder. We begin by describing briefly the major types of paraphilic disorders. As with sexual dysfunctions, it is unusual for an individual to have just one paraphilic pattern of sexual arousal.

Many patients may present with two, three, or more patterns, although one is usually dominant. Although paraphilic disorders are not widely prevalent and estimates of their frequency are hard to come by, some disorders, such as transvestic disorder (cross- dressing, discussed later), seem relatively common (Bancroft, 1989; Mason, 1997). You may have been the victim of **frotteuristic disorder** in a large city typically on a crowded subway or bus. (We mean really crowded, with people packed in like sardines.) In this situation, women have been known to experience more than the usual jostling and pushing from behind. What they discover, much to their horror, is a male with a frotteuristic arousal pattern rubbing against them until he is stimulated to the point of ejaculation. Because the victims cannot escape easily, the frotteuristic act is usually successful (Lussier & Piché, 2008).

Fetishistic Disorder

In fetishistic disorder, a person is sexually attracted to nonliving objects. There are almost as many types of fetishes as there are objects, although women's undergarments and shoes are popular. Fetishistic arousal is associated with two classes of objects or activities: (1) an inanimate object or (2) a source of specific tactile stimulation, such as rubber, particularly clothing made out of rubber. Shiny black plastic is also used. Most of the person's sexual fantasies, urges, and desires focus on this object. A third source of attraction (sometimes called partialism) is a part of the body, such as the foot, buttocks, or hair. In one U.S. city for several months, bras hung out on a woman's backyard clothesline disappeared. The women in the neighborhood soon began talking to each other and discovered that bras were missing from every clothesline for blocks around. A police stakeout caught the perpetrator, who turned out to have a strong fetish for brassieres. As another example of fetishistic behavior related to tactile stimulation, it is relatively common for a urologist to be called to the emergency room to remove surgically a long thin

object, such as a pencil or the arm of an eyeglass frame, from a man's urethra. Men who insert such objects think that partially blocking the urethra in this way can increase the intensity of ejaculation during masturbation. If the entire object slips into the penis, however, major medical intervention is required.

Voyeuristic and Exhibitionistic Disorders

Voyeuristic disorder is the practice of observing, to become aroused, an unsuspecting individual undressing or naked. Exhibitionistic disorder, by contrast, is achieving sexual arousal and gratification by exposing genitals to unsuspecting strangers (Lângstrom, 2010). Consider the case of Robert.

Outside the Curtains

Robert, a 31-year-old, married, blue-collar worker, reported that he first started "peeping" into windows when he was 14. He rode around the neighborhood on his bike at night, and when he spotted a female through a window he stopped and stared. During one of these episodes, he felt the first pangs of sexual arousal. Eventually he began masturbating while watching, thereby exposing his genitals, although out of sight. When he was older, he drove around until he spotted some prepubescent girls. He parked his car near them, unzipped his fly, called them over, and attempted to carry on a nonsexual conversation. Later he was sometimes able to talk a girl into mutual masturbation and fellatio, or oral stimulation of the penis. Although he was arrested several times, paradoxically, the threat of arrest increased his arousal (Barlow & Wincze, 1980).

Remember that anxiety actually increases arousal under some circumstances. Many voyeurs just don't get the same satisfaction from attending readily available strip shows at a local bar. Exhibitionistic disorder is often associated with lower levels of education, but not always. Note again that the thrilling element of risk is an important part of exhibitionistic disorder.

Although prevalence is unknown (Murphy & Page, 2008), in a random sample of 2,450 adults in Sweden, 31% reported at least one incident of being sexually aroused by exposing their genitals to a stranger, and 7.7% reported at least one incident of being sexually aroused by spying on others having sex (Làngstrom & Seto, 2006). To meet diagnosis for exhibitionistic disorder, the behavior must occur repeatedly and be compulsive or out of control.

Transvestic Disorder (Transvestic Fetishism)

In transvestic disorder, sexual arousal is strongly associated with the act of (or fantasies of) dressing in clothes of the opposite sex, or cross-dressing. The same survey in Sweden mentioned earlier found 2.8% of men and 0.4% of women reported at least one episode of transvestistic disorder (Làngstrom & Zucker, 2005) The 3% prevalence rate in males, while a rough estimate, is generally accepted (APA, 2013).

Interestingly, the wives of many men who cross-dress have accepted their husbands' behavior and can be quite supportive if it is a private matter between them. Docter and Prince (1997) reported that 60% of more than 1,000 men with transvestistic disorder were married at the time of the survey. Some people, both married and single, join cross-dressing clubs that meet periodically or subscribe to

newsletters devoted to the topic. If sexual arousal is primarily focused on the clothing itself the diagnostic criteria require a specification "with fetishism:' Research suggests that transvestism of this type is indistinguishable from other fetishes in most respects (Freund, Seto, & Kuban, 1996). Another specifier for transvestism describes a pattern of sexual arousal associated not with clothing itself but rather with thoughts or images of oneself as a female. This specifier is called "autogynephilia." Consider the case of Ron.

> *Ron was a 47-year-old divorced male with a 6-year-old son who lived with his son's mother. For the past several years, Ron had been living with his girlfriend and his girlfriend's 7-year-old daughter, mother, and sister. He was large and muscular with a short but full beard. His initial complaint was severe social anxiety, which he felt had interfered with his ability to make friends and advance in his job since he sought out positions that required only limited social interaction. He reported that he loved his girlfriend and wanted to get married and was particularly concerned about being the best father he could be for his son. He was assigned to group treatment for social anxiety, but he showed up for the first session much to our surprise dressed in a jean miniskirt, knee-high black leather boots, and a blouse. During the session he expressed considerable confusion about his sexuality, and we decided his needs would be better met in individual treatment.*
>
> *At that point, he requested to be called Rhonda and began volunteering a previous history of cross-dressing and frequenting gay nightclubs from time to time. He reported that his first marriage had ended after his wife discovered photos of him wearing her wedding dress. Presently, the most sexually arousing scenario for him was the image of himself as a woman, such as imagining himself performing domestic chores or activities such as cooking for a male partner while wearing an apron. But he was clear that it was not the clothes that were arousing so much as the image in his own mind of himself as a woman. He also reported engaging in risky sexual behaviors such as unprotected sex, meeting up with strangers to engage in sexual behaviors in parking lots, texting naked/provocative photos of himself to potential partners, and engaging in sexual acts in public places such as the gym shower, all of which would begin with him dressed in his female clothes and assuming the role of a woman. He had kept this behavior from his girlfriend mostly by hiding his clothes in the trunk of his car or in a back closet at work. In spite of this behavior, he maintained a strong and frequent sexual relationship with his girlfriend and was terrified of contracting AIDS and infecting her. He also couldn't imagine giving up the strong relationship with his son. Treatment focused on eliminating risky sexual behavior and clarifying with him the most important values in his life. He chose his girlfriend and his son and, after a course of treatment and occasional follow-up sessions, reported himself to be at peace with his decision and had given up his risky infidelities with no reports of slips or relapses.*

This specifier is very controversial because the "sexual confusion" experienced by Ron overlaps to some degree with gender dysphoria, and some think this confusion is better captured by the concept of gender dysphoria. Indeed, there is a somewhat greater risk that individuals with this paraphilic disorder will develop gender dysphoria and request transition through sex reassignment surgery (Blanchard, 2010; Lawrence, 2013). But as one can see in the case of Ron/Rhonda, gender dysphoria was not a major component of his presentation, and he did not once consider surgical sex reassignment. Rather, he was very strongly sexually aroused by thoughts and images of himself as a woman.

Sexual Sadism and Sexual Masochism Disorders

Both sexual sadism and sexual masochism are associated with either inflicting pain or humiliation (sadism) or suffering pain or humiliation (masochism; Hucker, 2008; Krueger, 2010a, 2010b; Yates, Hucker, & Kingston, 2008), and becoming sexually aroused is often associated with violence and injury in these conditions (Seto, Lalumiere, Harris, & Chivers, 2012). One client, Mr. M. was extremely concerned about his cross-dressing, but he was also disturbed by another problem. To maximize his sexual pleasure during intercourse with his wife, he had her wear a collar and leash, tied her to the bed, and handcuffed her. He sometimes tied himself with ropes, chains, handcuffs, and wires, all while he was cross-dressed. Mr. M. was concerned he might injure himself seriously. As a member of the police force, he had heard of cases and even investigated one himself in which an individual was found dead, tightly and completely bound in harnesses, handcuffs, and ropes. In many such cases, something goes wrong and the individual accidentally hangs himself, an event that should be distinguished from the closely related condition called hypoxiphilia, which involves self-strangulation to reduce the flow of oxygen to the brain and enhance the sensation of orgasm. It may seem paradoxical that someone has to either inflict or receive pain to become sexually aroused, but these types of cases are not uncommon. On many occasions, the behaviors themselves are quite mild and harmless (Krueger, 2010a; 2010b), but they can become dangerous and costly. It was not unusual that Mr. M. presented with three patterns of deviant arousal—in his case, sexual masochism, sexual sadism, and transvestism.

Psychological Treatment

A number of treatment procedures are available for decreasing unwanted arousal. Most are behavior therapy procedures directed at changing the associations and context from arousing and pleasurable to neutral. One procedure, carried out entirely in the imagination of the patient, called **covert sensitization**, was first described by Joseph Cautela (1967; see also Barlow, 2004). In this treatment, patients associate sexually arousing images in their imagination with some reasons why the behavior is harmful or dangerous. Before treatment, the patient knows about these reasons, but the immediate pleasure and strong reinforcement the sexual activity provides is enough to overcome any thoughts of possible harm or danger that might arise in the future. This process is what happens in much unwanted addictive behavior, where the short-term pleasure outweighs the long-term harm.

In imagination, harmful or dangerous consequences can be associated quite directly with the unwanted behavior and arousal in a powerful and emotionally meaningful way. One of the most powerful negative aspects of Tony's behavior was his embarrassment over the thought of being discovered by his current wife, other family members, or, most important, the family priest. Therefore, he was guided through the fantasy described here.

> *Imagining the Worst*
>
> *You are alone with your daughter in your trailer. You realize that you want to caress her breasts. So you put your arm around her, slip your hand inside her blouse, and begin to caress her breasts. Unexpectedly the door to the trailer opens and in walks your wife with Father X (the family priest). Your daughter immediately jumps up and runs out the door. Your wife follows her. You are left alone with Father X. He is*

> *looking at you as if waiting for an explanation of what he has just seen. Seconds pass, but they seem like hours. You know what Father X must be thinking as he stands there staring at you. You are embarrassed and want to say something, but you can't seem to find the right words. You realize that Father X can no longer respect you as he once did. Father X finally says, "I don't understand this; this is not like you." You both begin to cry. You realize that you may have lost the love and respect of both Father X and your wife, who are important to you. Father X asks, "Do you realize what this has done to your daughter?" You think about this and you hear your daughter crying; she is hysterical. You want to run, but you can't. You are miserable and disgusted with yourself. You don't know if you will ever regain the love and respect of your wife and Father X..*

During six or eight sessions, the therapist narrates such scenes dramatically, and the patient is then instructed to imagine them daily until all arousal disappears. His incestuous arousal was largely eliminated after 3 to 4 weeks, but the treatment did not affect his desire to interact with his daughter in a healthier manner. These results were confirmed by psychophysiological measurement of his arousal response. A return of some arousal at a 3-month follow up prompted us to ask Tony if anything unusual was happening in his life. He confessed that his marriage had taken a turn for the worse, and sexual relations with his wife had all but ceased. A period of marital therapy restored the therapeutic gains Several years later, after his daughter's therapist decided she was ready, she and Tony resumed a nonsexual relationship, which they both wanted.

Two major areas in Tony's life needed treatment: deviant (incestuous) sexual arousal and marital problems. Most individuals with paraphilic arousal patterns need a great deal of attention to family functioning or other interpersonal systems in which they operate. In addition, many require intervention to help strengthen appropriate desired patterns of arousal. In **orgasmic reconditioning**, patients are instructed to masturbate to their usual fantasies but to substitute more desirable ones just before ejaculation. With repeated practice, patients should be able to begin the desired fantasy earlier in the masturbatory process and still retain their arousal. This technique, first described by Gerald Davison (1968), has been used with some success in a variety of settings (Brownell et al., 1977; Maletzky, 2002). Finally, as with most strongly pleasurable but undesirable behaviors (including addiction), care must be taken to provide the patient with coping skills to prevent slips or relapses. Relapse prevention treatment created for addictions (Laws & O'Donohue, 1997) does just that. Patients are taught to recognize the early signs of temptation and to institute a variety of self- control procedures before their urges become too strong.

Evidence on the effects of psychological treatments for sexual offenders is decidedly mixed at this time. For sexual offenders who . have come into contact with the legal system, including those who are incarcerated (obviously a very severe group), the results are modest at best in terms of preventing later occurrences of offending (termed recidivism).

From: Abnormal Psychology, Barlow & Durand 8th Edition. Edited by Dr. Kramer