

KAPLAN & SADOCK'S  
**COMPREHENSIVE  
TEXTBOOK OF  
PSYCHIATRY**

**VOLUME I**

**EIGHTH**  **EDITION**

**EDITORS**

**Benjamin J. Sadock, M.D.**

Menas S. Gregory Professor of Psychiatry and  
Vice Chairman, Department of Psychiatry  
New York University School of Medicine  
Attending Psychiatrist, Tisch Hospital  
Attending Psychiatrist, Bellevue Hospital Center  
Consulting Physician, Lenox Hill Hospital  
New York, New York

**Virginia A. Sadock, M.D.**

Professor of Psychiatry  
New York University School of Medicine  
Attending Psychiatrist, Tisch Hospital  
Attending Psychiatrist, Bellevue Hospital Center  
New York, New York



**LIPPINCOTT WILLIAMS & WILKINS**

A Wolters Kluwer Company

Philadelphia • Baltimore • New York • London  
Buenos Aires • Hong Kong • Sydney • Tokyo

*Acquisitions Editor:* Charles W. Mitchell  
*Developmental Editors:* Joyce Murphy and Lisa Kairis  
*Supervising Editors:* Melanie Bennitt and Nicole Walz  
*Production Editors:* Alyson Langlois and Kate Sallwasser, Silverchair Science + Communications  
*Senior Manufacturing Manager:* Ben Rivera  
*Marketing Manager:* Adam Glazar  
*Compositor:* Silverchair Science + Communications  
*Printer:* Quebecor World Taunton

© 2005 by LIPPINCOTT WILLIAMS & WILKINS  
530 Walnut Street  
Philadelphia, PA 19106 USA  
LWW.com

"Kaplan Sadock Psychiatry" with the pyramid logo is a trademark of Lippincott Williams & Wilkins.

All rights reserved. This book is protected by copyright. No part of this book may be reproduced in any form or by any means, including photocopying, or utilized by any information storage and retrieval system without written permission from the copyright owner, except for brief quotations embodied in critical articles and reviews. Materials appearing in this book prepared by individuals as part of their official duties as U.S. government employees are not covered by the above-mentioned copyright.

Printed in the USA

---

#### Library of Congress Cataloging-in-Publication Data

Kaplan & Sadock's comprehensive textbook of psychiatry / editors, Benjamin J. Sadock, Virginia A. Sadock.-- 8th ed.

p. ; cm.

Includes bibliographical references and index.

ISBN 0-7817-3434-7

1. Psychiatry. I. Title: Kaplan and Sadock's comprehensive textbook of psychiatry. II. Title: Comprehensive textbook of psychiatry. III. Sadock, Benjamin J., 1933- IV. Sadock, Virginia A. V. Kaplan, Harold I., 1927- [DNLM: 1. Mental Disorders. 2. Psychiatry. WM 100 K173 2004]

RC454.C637 2004

616.89--dc22

2004018805

---

Care has been taken to confirm the accuracy of the information presented and to describe generally accepted practices. However, the authors, editors, and publisher are not responsible for errors or omissions or for any consequences from application of the information in this book and make no warranty, expressed or implied, with respect to the currency, completeness, or accuracy of the contents of the publication. Application of this information in a particular situation remains the professional responsibility of the practitioner.

The authors, editors, and publisher have exerted every effort to ensure that drug selection and dosage set forth in this text are in accordance with current recommendations and practice at the time of publication. However, in view of ongoing research, changes in government regulations, and the constant flow of information relating to drug therapy and drug reactions, the reader is urged to check the package insert for each drug for any change in indications and dosage and for added warnings and precautions. This is particularly important when the recommended agent is a new or infrequently employed drug.

Some drugs and medical devices presented in this publication have Food and Drug Administration (FDA) clearance for limited use in restricted research settings. It is the responsibility of the physician or health care provider to ascertain the FDA status of each drug or device planned for use in their clinical practice.

10 9 8 7 6 5 4 3 2 1

age, race, class, geographical location, and religion. Many studies continue to focus on white, urban, middle-class men, and there is a need to study sexual diversity in other groups as well. There is also a need for ongoing longitudinal studies about the development and experience of sexual orientation and sexual identity over time and across the life span. Longitudinal studies can also expand understanding about those childhood characteristics that contribute to the development of an adult sexual orientation, as well as those factors that shape individual expression of desire and behavior. Future research will inevitably expand beyond traditional biological and psychosocial approaches and will use constructivist methodologies to account for the role of fluctuating cultural and other historical forces in shaping individual lives and experience.

## SUGGESTED CROSS-REFERENCES

Normal child development is discussed in Section 32.2, and normal adolescent development is discussed in Section 32.3. Normal human sexuality, other than homosexuality and homosexual behavior, and sexual dysfunctions are discussed in Section 18.1a. Gender identity disorders are discussed in Section 18.3. The psychotherapies are discussed in Chapter 30. Neuropsychiatric aspects of HIV infection and AIDS are discussed in Section 2.8. Contributions of the sociocultural sciences are discussed in Chapter 4. The psychiatric interview is discussed in Section 7.1. Substance-related disorders are discussed in Chapter 11. Ethics in psychiatry are discussed in Section 54.2.

## REFERENCES

- American Psychiatric Association: Commission on Psychotherapy by Psychiatrists (COPP): Position statement on therapies focused on attempts to change sexual orientation (Reparative or conversion therapies). *Am J Psychiatry*. 2000;157:1719.
- Arnold P, Agate RJ, Carruth LL: Hormonal and nonhormonal mechanisms of sexual differentiation of the brain. In: Legato M, ed. *Principles of Gender Specific Medicine*. San Diego: Elsevier Science, 2004:84.
- \*Bayer R. *Homosexuality and American Psychiatry: The Politics of Diagnosis*. Princeton, NJ: Princeton University Press; 1987.
- Bell AP, Weinberg MS, Hammersmith FK: *Sexual Preference: Its Development in Men and Women*. Bloomington, IN: Indiana University Press; 1981.
- Boswell J. *Same-Sex Unions in Premodern Europe*. New York: Villard Books; 1994.
- \*Byne W: The biological evidence challenged. *Sci Am*. 1994;270:50-55.
- Byne W, Parsons B: Human sexual orientation: The biologic theories reappraised. *Arch Gen Psychiatry*. 1993;50:228.
- Byne W, Sekaer C: The question of psychosexual neutrality at birth. In: Legato M, ed. *Principles of Gender Specific Medicine*. San Diego: Elsevier Science, 2004:155.
- \*Cabaj RP, Stein TS. *Textbook of Homosexuality and Mental Health*. Washington, DC: American Psychiatric Press; 1996.
- D'Augelli AR, Patterson CJ. *Lesbian, Gay, and Bisexual Identities Over the Lifespan: Psychological Perspectives*. New York: Oxford University Press; 1995.
- DeCecco JP, Parker DA, eds. *Sex, Cells, and Same-Sex Desire: The Biology of Sexual Preference*. New York: Haworth Press; 1995.
- \*Drescher J. *Psychoanalytic Therapy and the Gay Man*. Hillsdale, NJ: The Analytic Press; 1998.
- Ford CS, Beach FA. *Patterns of Sexual Behavior*. New York: Harper & Row; 1951.
- Foucault M. *The History of Sexuality, Volume 1: An Introduction*. Hurlley R, trans. New York: Pantheon; 1978.
- Freud S. Three essays on the theory of sexuality. In: *Standard Edition of the Complete Psychological Works of Sigmund Freud*. Vol 7. London: Hogarth Press; 1996.
- Greenberg DF. *The Construction of Homosexuality*. Chicago: University of Chicago Press; 1988.
- Guss JF, Drescher J, eds. *Addictions in the Gay and Lesbian Community*. New York: Haworth Press; 2000.
- Herdt G. *Guardians of the Flutes: Idioms of Masculinity*. Chicago: University of Chicago Press; 1994.
- Herek GM, Berrill KT, eds. *Hate Crimes*. Newbury Park, CA: Sage Publications; 1992.
- Hooker EA: The adjustment of the male overt homosexual. *J Projective Techniques*. 1957;21:17.
- Isay R. *Being Homosexual: Gay Men and Their Development*. New York: Farrar, Straus and Giroux; 1989.
- Kernberg OF: Unresolved issues in the psychoanalytic theory of homosexuality and bisexuality. *J Gay Lesb Psychother*. 2002;6:9.
- Kinsey AC, Pomeroy WB, Martin CE. *Sexual Behavior in the Human Male*. Philadelphia: WB Saunders; 1948.
- Kinsey AC, Pomeroy WB, Martin CE, Gebhard P. *Sexual Behavior in the Human Female*. Philadelphia: WB Saunders; 1953.

- Lasco M, Jordan T, Edgar M, Petito C, Byne W: A lack of dimorphism of sex or sexual orientation in the human anterior commissure. *Brain Res*. 2002;936:95.
- Laumann EO, Gagnon JH, Michael RT, Michaels S. *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago: University of Chicago Press; 1994.
- LeVay S, Hamer DH: Evidence for a biological influence in male homosexuality. *Sci Am*. 1994;270:44-49.
- Lingiardi V, Drescher J, eds. *The Mental Health Professions and Homosexuality: International Perspectives*. New York: Haworth Press; 2003.
- Magee M, Miller D. *Lesbian Lives: Psychoanalytic Narratives Old and New*. Hillsdale, NJ: The Analytic Press; 1997.
- Malyon A: Psychotherapeutic implications of internalized homophobia in gay men. *J Homosex*. 1982;1:59.
- McWhirter DP, Sanders SA, Reinisch, eds. *Homosexuality/Heterosexuality: Concepts of Sexual Orientation*. New York: Oxford University Press; 1990.
- Mustanski BS, Chivers ML, Bailey JM: A critical review of recent biological research on human sexual orientation. *Annu Rev Sex Res*. 2002;89.
- Sandfort TGM: Studying sexual orientation change: A methodological review of the Spitzer study. "Can some gay men and lesbians change their sexual orientation?" *J Gay Lesbian Psychother*. 2003;7:15.
- \*Shidlo A, Schroeder M, Drescher J, eds. *Sexual Conversion Therapy: Ethical, Clinical and Research Perspectives*. New York: Haworth Press; 2001.
- Spitzer RL: Can some gay men and lesbians change their sexual orientation? 200 subjects reporting a change from homosexual to heterosexual orientation. *Arch Sex Behav*. 2003;32:403.
- Stein TS, Cohen CJ, eds. *Contemporary Perspectives on Psychotherapy with Lesbians and Gay Men*. New York: Plenum Publishing; 1986.
- Weinberg MS, Williams CJ, Pryor DW. *Dual Attraction: Understanding Bisexuality*. New York: Oxford University Press; 1994.

## ▲ 18.2 Paraphilias

ETHEL SPECTOR PERSON, M.D.

Sexual symptoms fall readily into two groups; they are pleasure inhibitors or pleasure facilitators, and the sexual disorders can be classified accordingly. In the first group, referred to as *sexual dysfunctions*, the patient experiences an impairment, most often an inhibition, in the initiation of the sexual cycle, in sexual arousal, or in the ability to achieve orgasm. In other words, there is impairment of desire, sexual arousal, or orgasm. In the second group, the *paraphilias* (previously labeled as *perversions* or *deviations*), the sexual response is preserved, but the symptom, a significant deviation in the erotic stimulus or in the activity itself, is the precondition for sexual excitement and orgasm.

In the paraphiliac, sexual excitement is contingent on the invocation or enactment, or both, of a specific fantasy that is unusual or sometimes even bizarre. Conversely, sexual excitement and arousal do not occur or are diminished if, for whatever reason, the accompanying paraphiliac fantasies are suppressed. This is at the heart of the difficulty in curing or controlling paraphilias; it is hard for people to give up sexual pleasure with no assurance that new routes to sexual gratification will be secured. Moreover, the paraphiliac sexual scripts often serve other vital psychic functions. They may assuage anxiety, bind aggression, or stabilize identity.

Sigmund Freud originally described *perversion* (paraphilia) as comprising a distortion in sexual aim, that is, in the nature of the activity, for example, urolagnia, urinating on the object as a prerequisite to arousal. He broadened the definition to include distortions in the choice of the sexual object. Distortions in the aim or the object constitute a paraphilia only when they are prerequisite to the sexual act, that is when they are obligatory rather than elective. For example, if a man achieves sexual excitement only in response to a sheep as an object (in fantasy or actuality), his sexuality would be consid-

ered perverse. In contrast, the sexual behavior of a herdsman who resorts to intercourse with a sheep in the absence of an appropriate object might be considered to be engaged in a sexual variation rather than in acting out a paraphiliac desire. Even so, because masturbation (with its attendant fantasy) always exists as a sexual outlet, the choice of an animal object might suggest that the herdsman had some minor perverse strain. It may be of some interest that *The Goat*, Edward Albee's play, which depicts the unraveling of a marriage when the husband falls in love with a goat, won the 2002 Tony Award for the best dramatic play. Albee expressed his pleasure that a love story should have taken first prize.

With the possible exception of sadism and masochism, the paraphilias are relatively rare compared to sexual dysfunctions. Yet, paraphilias have claimed just as much attention as the sexual dysfunctions. In part, this may be because so many people have strands of perverse interest woven into their sexual makeup that fly just under the radar of consciousness but that express themselves in self-evident interest in films and books that feature one or another paraphilia. This interest can be inferred from a quick look at the bestseller lists, which often feature books depicting masochistic surrender or serial sexual murders. Moreover, newspapers, magazines, and television play to this interest with stories of sex crimes, some of which, like pedophilia, are paraphilias.

To fully understand the clinical presentation of the paraphilias, the fundamental definitions and conceptualizations of sex and sexuality and their interrelationship should be considered. *Sex* refers to biological sexuality and is defined by six component parts: chromosomes, gonads, internal genitalia, external genitalia, sex hormones, and secondary sexual characteristics. *Sexuality*, in contrast to biological sex, refers to erotic excitement, genital arousal, and orgasm. It is expressed in fantasy and behavior, object choice, subjective desire, arousal, preferred activities, and orgasmic discharge.

Each individual, whether paraphiliac or not, develops a characteristic pattern of sexual expression—sometimes called a *sex print* or *love map*. This pattern constitutes an erotic signature, signifying that the individual's sexual potential has been progressively narrowed between infancy and adulthood. It conveys more than just a preference for a particular sexual object and activity; it also indicates that an individualized script, that is, a specific fantasy or group of fantasies is the most reliable and, sometimes, the necessary prerequisite to elicit erotic desire. From the subjective point of view, such preferences are almost always thought of as deep rooted and stemming from a person's nature rather than as conditioned by experience. Consequently, the sex print or love map often forms part of a person's conscious identity or sense of self and, as such, may be regarded as sexual identity. Although the *sex print* or *love map* refers to sexual fantasies and observable sexual practices and preferences, *sexual identity* refers to the internal experience of sexual arousal patterns and self-labeling.

For most heterosexuals and homosexuals, male or female, the sex print encompasses an evolving series of several different fantasies. In contrast, in paraphiliacs, the sex print is much narrower. Similarly, although most heterosexuals and homosexuals can achieve sexual arousal under a fairly wide set of circumstances, in a full-blown paraphilia, a stereotypical paraphiliac fantasy, its depiction in pornography, or its enactment is almost always prerequisite to arousal. Although most paraphiliacs favor one fantasy, some rotate interest among several different paraphiliac fantasies.

The study of paraphilias stands on its own, but it has also proved relevant to theories of sexual development. The study of the perversions (paraphilias) was decisive in Freud's formulations of normal psychosexual development and culminated in his publication of

*Three Essays on the Theory of Sexuality*. Analogously, the study of the gender identity disorders, particularly transsexualism, later played a pivotal role in contemporary reconceptualizations of gender. These are both examples of how the study of a phenomenon that, at first, appears to be marginal sometimes opens up new vistas of knowledge.

## DEFINITION

In the classical case of paraphilia, paraphiliac fantasies or stimuli are obligatory to erotic arousal. However, a paraphiliac preference may occur episodically, especially during stress, whereas, at other times, the same individual may be able to function sexually without the benefits of paraphiliac fantasies or stimuli. According to the revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), to diagnose a paraphilia, the patient must have recurring, intensely arousing fantasies, sexual urges or behaviors that involve nonhuman objects; that involve the suffering or humiliation of oneself, one's partner, children, or nonconsenting others; and that occur over a period of at least 6 months (Criterion A). In addition, the behavior, sexual urges, and fantasies must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). What this definition fails to do is delineate the difference between paraphilias that are harmful to others and that may even be criminal, including pedophilia, exhibitionism, voyeurism, frotteurism, and those that are not necessarily physically or psychologically harmful to others. This is an important distinction for practical, as well as theoretical, reasons. The two groups generally receive different therapeutic interventions, and the genesis of their disorders is understood somewhat differently. It is the group of paraphilias that causes harm that stigmatizes the whole group and leads one to think of paraphilias as invariably pernicious. In fact, some well-known and productive individuals have had perversions, including the sexologist Havelock Ellis, who wrote in his autobiography of his urolagnia.

The paraphilias include *exhibitionism* (exposure of one's genitals), *fetishism* (use of nonliving objects), *frotteurism* (rubbing against or touching a nonconsenting person), *pedophilia* (sexual fantasy preoccupation or sexual activity with prepubescents), *sexual masochism* (seeking humiliation or suffering), *sexual sadism* (inflicting humiliation or suffering), *transvestic fetishism* (the obligatory use of clothing of the opposite sex to achieve arousal), and *voyeurism* (arousal through viewing another person's undressing, toileting, or sexual activity). There is a residual category, *paraphilia not otherwise specified*, that includes less frequently encountered paraphilias. It includes such behaviors as *infantilism* (dressing in diapers or requiring a partner who does so) or the requirement that a sexual partner has an amputated limb. In fact, more than 40 conditions qualify as paraphilias.

Some paraphiliacs eschew intercourse in favor of masturbation; for example, voyeurs and exhibitionists may favor masturbation accompanying the pornographic act to any sexual congress, heterosexual or homosexual. Transvestic fetishists, too, show a diminished, although not absent, interest in sexual intercourse. Some individuals are polymorphous perverse and use a number of different paraphiliac fantasies that coexist, whereas others may have paraphiliac preferences that migrate from one paraphilia to another over the course of time. If an individual's preferences meet the criteria for more than one paraphilia, all must be diagnosed.

**Associated Features and Disorders** Although paraphilias are predominantly disorders of sexuality, they are sometimes associated with some deviation in gender role identity. Paraphilias and gender identity disorders sometimes exist on a continuum. For example, a transvestic fetishist

may use cross-dressing primarily fetishistically—that is, to achieve sexual arousal—in which case, his disturbance would be diagnosed as a paraphilia, whereas, to the degree that a transvestic fetishist progresses to complete cross-dressing to relieve his anxiety and to stabilize his identity, his disturbance would be more likely to be diagnosed as a cross-gender disorder.

## HISTORY

Sex has always been regarded as a force that must be reckoned with. Before the subject of sex was medicalized and became the object of study of sexologists and psychiatrists, it was regulated by religious precepts. Under religious auspices, deviation from the norm was regarded as sinful or criminal rather than pathological. In today's world, the precepts of various religions continue to determine what is thought of as acceptable, although, to some degree, the authority of religion has been eroded by the findings in the burgeoning field of sex research.

The scientific study of sex began in the late 19th century. Although various paraphilias have existed as long as recorded history, they enter into the scientific dialogue courtesy of the psychiatrist Richard von Krafft-Ebing (1840 to 1902), who labeled *sadistic* behavior as such, deriving the term from the writings of the Marquis de Sade, an 18th-century French nobleman. Leopold von Sacher-Masoch, an Austrian born in the 19th century, wrote novels that dealt with masochistic themes, and it is from his name that the term *masochism* is derived. It is through Krafft-Ebing's detailed clinical descriptions of a range of sexual disorders that the scientific study of sex was born. In 1895, the psychologist Albert von Schrenk-Notzing linked sadism and masochism together into the term *algolagnia*, emphasizing the connection between sexual excitement and pain. In 1938, Freud affirmed this association through his invocation of the term *sadomasochism*. In 1966, John Money created a research program for the psychohormonal treatment of *perversions* (paraphilias) and sex-offender syndromes. This was the same year that William Masters and Virginia Johnson published their landmark book on normal human sexuality.

*Paraphilias*, or *sexual deviations*, as they are frequently called, imply a deviation from normative patterns. However, there is a fundamental problem in delineating the paraphilias in this way: No definitive description of what entails normal can be established, because definitions of normality change over time. One of the most striking examples is the psychiatric profession's reversal of its views on homosexuality in the late 1960s. Although homosexuality was long considered an aberration, it was first labeled as a paraphilia in 1968 in the second edition of the DSM (DSM-II). However, psychiatrists shortly reversed themselves on grounds that there was no evidence that homosexuality was anything more than a sexual variation, that is, that it was not invariably associated with any discernible disabilities different from those of heterosexuals. This turnaround in the United States occurred in the context of the gay liberation movement of the 1960s. Only in 1978 did the sexologists Alan P. Bell and Martin S. Weinberg confirm through a large-scale study of homosexuals that there were no significant differences in the psychological disabilities attached to homosexuals and heterosexuals. However, not all psychiatrists and psychoanalysts worldwide have accepted this change in thinking. For example, a large number, and perhaps the majority, of psychoanalysts in Latin America still consider homosexuality to be perverse.

Freud had come close to the North American position a half century earlier. He asserted the normality of homosexuals, declaring that inverts were a group of individuals who might be quite sound in all other respects. (Note, however, the implication that homosexuals

were not sound in one respect.) Although the psychiatric profession's turnaround (before Bell and Weinberg's study) has been widely applauded, and rightly so, it nonetheless suggests that the psychiatric profession's criteria for classification of the paraphilias are not altogether based on scientific criteria. In essence, the exemption of homosexuality as a paraphilia raises questions about the methodology by which what constitutes a perversion is judged.

Paraphilias, unlike neurotic symptoms, provide pleasure of the highest order and may sometimes be ego-syntonic. The question necessarily arises as to why some sexual fantasies and behaviors are considered pathological rather than merely different. Some liberation groups, such as sadomasochism liberation (based on the model of gay liberation), question whether the psychiatric profession is labeling some sexual behaviors perverse or deviant on moral grounds in the guise of medical ones. A number of sexologists have pointed out that there is a major difference in paraphilias that are limited to an eccentric expression of sexuality (for example, fetishism) and those that may be harmful to others (for example, pedophilia).

Despite the medical, psychiatric, and legal interest in paraphilia, its scientific study is limited by access to subjects. Most ideas on paraphilias are based on information gathered from patients whose paraphilia troubles them or from paraphiliacs who have run afoul of the law. It is not reliably known what percentage of the population might be diagnosed as paraphiliacs.

The major limitation to any absolute claim of abnormality in paraphiliacs is the failure of psychiatrists to study large groups of nonpatient paraphiliacs. To scientifically conclude the degree to which a particular paraphilia is connected to psychological disabilities would depend on large-scale studies of nonpatient populations. These results would then need to be compared to psychological disabilities in a nonparaphiliac sample. This research could only be done through field work in which investigators identified a large sample of nonpatient paraphiliacs. Some such studies have been conducted with transvestites—now called *transvestic fetishists*. The existence of a transvestic subculture made access to research subjects relatively easy. Several studies of nonpatient transvestites support the contention that the full-blown transvestic syndrome is associated with disabilities and impairment that warrant the designation of disorder, for example, the hyposexuality that so often accompanies it and the high incidence of depression often linked to it. However, comparable studies have not yet been systematically carried out with respect to most of the other sexual deviations. Alfred Kinsey's sexual surveys were so important precisely because he studied sexuality in a nonpatient population. This methodology, of course, was what made Bell and Weinberg's study on homosexuality so compelling. There are suggestions that so-called perverse interests may be more extensive than may be thought. One hint of this comes from the Internet, which has generated any number of sexual sites devoted to a variety of sexual deviations.

## COMPARATIVE NOSOLOGY

The criteria for diagnosing paraphilias have been revised time and again over the past 50 years. In the first edition of the DSM (DSM-I) (1952), sexual deviations were grouped with psychopathic personality disturbances. Such a classification reflected the fact that the enactments of certain paraphilias are legal offenses (e.g., pedophilia and exhibitionism), but the classification also suggests the possibility that the society held pejorative attitudes toward all deviations. At that time, homosexuality was included among the sexual deviations. In DSM-II (1968), sexual deviations were classified with the person-

ality disorders. By 1980, with the publication of the third edition of the DSM (DSM-III), the term *paraphilia* was substituted for the term *perversion*. In part, the name change was made because the term *paraphilia* is descriptive. As noted in DSM-III, "The deviation (para) is in that to which the individual is attracted (philia)." But the name change was also meant to be nonjudgmental, because it was felt that the term *perversion* carried a negative connotation. The whole group of paraphilias was reclassified under the category of psychosexual disorders, which also included gender identity disorders, psychosexual dysfunctions, and ego-dystonic homosexuality. These changes reflect a shift in attitude among psychiatrists and the general public as well—the unwillingness to stigmatize a patient for symptoms beyond his or her control, particularly because not all of the paraphilias come within the purview of current law.

A major change in the revised edition of the DSM-III (DSM-III-R) was to retract the idea that, to make the diagnosis of paraphilia, the paraphiliac acts had to be the preferred or exclusive means of achieving sexual pleasure. The diagnosis was extended to those who might prefer heterosexual intercourse but who had entertained significant paraphiliac fantasies over the past 6 months.

DSM-IV-TR diagnoses paraphilias on the basis that they may entail interference with "the capacity for reciprocal, affectionate sexual activity." To make the diagnosis, the individual must have acted out his or her paraphiliac fantasy or must be distressed by the fantasy for at least 6 months.

To qualify as a DSM-IV-TR diagnosis, the sexual patterns must have persisted for a period of at least 6 months (Criterion A) and must have caused clinically significant distress or impairment in social, occupational, or other important areas of function (Criterion B). DSM-IV-TR emphasizes that, although, for some individuals, the paraphiliac fantasies are merely stimulating, for others, they are obligatory to arousal and are always included in sexual activity. In some other cases, these preferences occur only episodically, particularly during periods of stress; that is, there are times when the individual can function sexually without such fantasies or stimuli. The changes made in DSM-IV-TR go a long way toward addressing the critique that labeling one or another sexual preference as a paraphilia is arbitrary. They argue that the diagnosis of paraphilia must rest on the existence of some disability or impairment that attaches to the sexual act so designated. The downside here is that the paraphilias may fail to be seen as a spectrum in which harmless perversions are incorporated into productive lives. Havelock Ellis might serve as an example here.

DSM-IV-TR draws special attention to the paraphiliac fantasies and imagery that are acted out with a nonconsenting partner. Sexual sadism and pedophilia are generally thought to be injurious to the partner. (It should be noted, however, that sexual sadism is often enacted with a consenting partner, whose sexual pleasure is dependent on masochistic gratification.) The paraphiliac enactment can lead to arrests and imprisonment. Sexual offenses against children account for a large proportion of all reported criminal sex acts. Exhibitionists and voyeurs, along with pedophiles, make up most of those sex offenders who are arrested. Although not creating as much devastation in their victims as do pedophiles, exhibitionists, voyeurs, and frotteurists often frighten their victims.

No classification is without its contradictions. Several experts have observed that paraphiliacs who are sexual offenders are more stressed by the discovery of their crimes than by guilt over the harm that they inflict. This is unlike that group of paraphiliacs who seek therapy because of psychic pain or stress within the family. This bifurcation suggests that the paraphilias may encompass at least two different groups of disorders. The classification of paraphiliacs might be improved by distinguishing between those who pose a threat to others and those who do not.

DSM-IV-TR may also go awry in relabeling transvestism as *transvestic fetishism* and in subsuming it entirely within the paraphilias as distinct from the disorders of gender identity. A significant number of transvestic fetishists

evolve into transsexuals, and, in most transvestic fetishists, there is a component of cross-gender identification. It is clear, for example, that three different categories of patients may evolve into transsexuals: transvestites, extreme cross-dressing homosexuals, and a category that is generally referred to as *primary transsexuals*.

**Rationale for the Classification** An evolutionary value system is no longer held in which sexuality must be tied to reproduction to be considered normal and in which all other sexuality is considered suspect. However, there are grounds for preserving the concept and classification of paraphilias without invoking an evolutionary imperative. Two lines of argument have been invoked to demonstrate the legitimacy of this classification, one philosophic, the other psychiatric.

Philosophers have observed that the fact that humans even possess a concept of sexual perversion tells something about sex. Social disapproval is insufficient to label something as perverse. Thus, although adultery may be viewed as a moral outrage, it has not been labeled as perverse. Although some religions believe that masturbation is a sin, no one claims it is perverse. This suggests that paraphilias convey something unnatural rather than immoral. How to distinguish what is natural from what is unnatural is at the heart of the problem. Some sexual activities, such as heterosexual intercourse, are clearly normal, whereas such sexual acts as shoe fetishism are clearly paraphilias. Still other sexual behaviors may fall somewhere in between.

The argument in DSM-IV-TR, similar to the philosophical perspective, is that people with paraphilias have some impairment in their capacity for reciprocal affectionate sexual activity. This argument, however, is permeated with value biases, evident in the fact that it is not universally applied. Compulsive promiscuity is not listed among the paraphilias, and neither is lovelessness in couples. The boundary between perverse and normal sexuality is not always clear cut.

The validity of the classification of paraphilias must rest on specific criteria. To make the diagnosis of perversion, there must be evidence that the perverse fantasy or activity permeates mental life to an unusual degree, that its suppression yields high-level anxiety or dysphoric affect, or that it is connected with some other personality dysfunction. In the more overt cases, those usually seen in clinical practice, these claims appear to be adequately demonstrated. However, there are many instances in which perverse elements are subsumed into sexuality in such a minor key that the diagnosis of perversion is not warranted.

## EPIDEMIOLOGY

**Gender Ratio** One characteristic feature of the distribution of the paraphilias is remarkable: the enormous predominance of paraphilias in men. Except for sadism and masochism, almost all of the reported cases are in men. This preponderance in men is characteristic not just of the paraphilias, but also, to a much lesser degree, of the gender disorders. Any attempt to explain this discrepancy must be related to understanding of the etiology of the paraphilias. Insofar as etiology has not been conclusively demonstrated, explanations can only be tentative.

**Prevalence** Insofar as a paraphilia yields pleasure, many individuals so affected do not seek psychiatric intervention. Even those who feel anguished may avoid confiding in a doctor or psychiatrist out of profound shame. Restricted to studying a psychotherapy

patient population or a population convicted of sexual crimes, relatively little is known about the incidence and distribution of the paraphilias or about the natural history of the course of any given paraphilia over time.

Some paraphilias appear to be more common than others. In an individual psychiatric practice, masochism, sadism, and fetishism appear to be the most commonly encountered paraphilias, whereas the excretory perversions are rarely seen. In contrast, in clinics that specialize in the treatment of sex offenders against whom criminal charges have been raised, the most commonly encountered paraphilias are pedophilia, voyeurism, and exhibitionism.

It has long been thought that, because some paraphilias depend on the participation of nonconsenting individuals and come to the attention of the courts (e.g., pedophilia and exhibitionism), they might be overrepresented in attempts to determine relative frequencies. Yet, as it turns out, many pedophiles have been sheltered from the law. Pedophilia has recently exploded onto the world stage by virtue of the crisis within the Catholic Church; the Church is being criticized for its reluctance to acknowledge the sexual abuse perpetrated by priests, the most egregious of these abuses being pedophilia. Given that the actual incidence of paraphilias involving nonconsenting individuals or the number of paraphiliacs who fail to seek psychiatric help is not known, the incidence of any one of the paraphilias is clearly underreported.

Something is known about the range of sexual behaviors, the variety of sexual fantasies, and the high incidence of sadomasochistic fantasies in a nonpatient population. For example, one study elicited the male and female responses of 193 university students to questions about sexual experience and sexual fantasies. The study differentiated recent and cumulative behaviors and recent sexual fantasies and cumulative sexual fantasies.

Sexual behavior showed only a modest degree of gender influence. Because the population was predominantly heterosexual, it was no surprise that there was a close correlation between male and female behaviors. Most behavioral items referred to interpersonal consensual activity. Those behaviors most frequently enacted were romantic, traditional, nongenital sexual encounters, closely followed by sexual intercourse and its variations.

In their report of recent sexual experiences, 1 percent of the women and 1 percent of the men reported being tortured, 1 percent of women and 1 percent of men reported being whipped or beaten by a partner, 1 percent of women and 1 percent of men reported degrading a sexual partner, 1 percent of women and 3 percent of men reported forcing a partner to submit, 0 percent of women and 4 percent of men reported exhibiting their body in public, and 0 percent of women and 2 percent of men reported whipping or beating a partner. A few cumulative sexual experiences were statistically significant for gender differences: Thirteen percent of women and 4 percent of men reported being forced to submit, and 8 percent of women and 21 percent of men reported exhibiting their body in public.

Greater differences between men and women emerged in their self-reports of fantasies, which was not an unanticipated finding, because fantasies, by virtue of being independent, are more likely to reveal individual desires.

Twenty percent of women in the study reported recent sexual fantasies of being forced to submit, 20 percent reported being tied or bound during sexual activity, 12 percent reported being sexually degraded, 10 percent reported being prostituted, 9 percent reported being tortured by a sexual partner, 8 percent reported being whipped or beaten by a partner, 5 percent reported forcing a partner to submit, 1 percent reported whipping or beating a partner, and 1 percent reported degrading a sex partner. Comparable percentages in men

were 15 percent reporting being forced to submit, 15 percent reporting being tied or bound, 5 percent reporting being degraded, 5 percent reporting being prostituted, 5 percent reporting being tortured, 5 percent reporting being whipped or beaten, 31 percent reporting forcing to submit, 7 percent reporting whipping or beating, and 7 percent reporting degrading. Six percent of men also reported fantasies of torturing a sex partner.

In the cumulative sexual fantasies, both genders reported the same level of ongoing masochistic fantasies: being tortured by a sex partner (10 percent of women, 11 percent of men), being whipped (15 percent of women, 14 percent of men), being brought into a room against one's will (20 percent of women, 15 percent of men), being tied or bound during sex activities (30 percent of women, 31 percent of men), and being forced to submit (31 percent of women, 27 percent of men). The one item that may suggest a female tendency to passivity or masochism is the fantasy of being rescued from danger by one who will become a lover. However, the fantasy preoccupation with domination showed significant gender differences. Forty-four percent of the men reported the fantasy of forcing a sexual partner to submit. A smaller number reported other sadistic fantasies: whipping, 20 percent; degrading, 15 percent; and torturing, 12 percent.

Of the significant minority of subjects who had sadomasochistic fantasies, more men reported sadistic content, whereas both genders reported similar levels of masochistic content. However, the study was not designed so as to estimate how many of the subjects might be classified as paraphiliacs. What is certain is that, although both genders have a significant fantasy preoccupation with sadism and masochism, enactments are infrequent. Nonetheless, the relatively high incidence of sadomasochistic fantasies compared to other kinky fantasies suggests that power issues in growing up lend themselves to widespread incorporation of sadomasochistic concerns into fantasy life.

## ETIOLOGY

The etiology of the paraphilias is not definitively known. Brain abnormalities or biological predispositions, identification with parents who have paraphilias, developmental adversity of a greater or lesser degree, and psychological conflict have all been proposed as potential etiologies for paraphilias, whether singly or in concert.

The inability to explain etiology in paraphilias is not so odd when it is considered that the etiology of heterosexuality or homosexuality is not fully understood. The argument for an exclusive biological causality is difficult to support. Kinsey and colleagues pointed out that the argument that homosexuality was biological could not account for the fact that there were no replicable distinguishing data (such as hormone assays) and, moreover, that homosexuality and heterosexuality were not mutually exclusive but could coexist in all combinations. Similarly, when the etiology of preferential heterosexual choice is considered, the best data suggest that it may be the result of postnatal experience. This having been said, it should be reiterated that the etiology of heterosexuality and homosexuality, like that of the paraphilias, remains unknown.

## Brain Abnormalities or Biological Predispositions

Some studies indicate that, among sex offenders seeking treatment, those with congenital or acquired brain damage are overrepresented. Similarly, clinicians have observed that, after brain damage, whether the result of accidents, surgery, epilepsy, or toxic substances, anomalous sexual behaviors, including paraphilias, may emerge. Investigators have observed a link between sexually

anomalous behavior and temporal lobe impairment or temporal lobe epilepsy. Different theories have been proposed to explain what the connection might be between brain abnormalities and paraphilias. They include the idea that a brain abnormality diminishes the individual's control over preexisting paraphiliac impulses, that it releases impulses otherwise repressed, that it disadvantages the individual thus afflicted, that it leads to paraphiliac substitutions, or that it may be a direct result of damage to cerebral wiring. It certainly may be that some biological vulnerability or predisposition facilitates a pattern of variant psychosexual development. Even if some biological predisposition is ultimately implicated, its influence would be mediated in interaction with cognitive, affective, and experiential development.

**Identification with Parents** There is some evidence that there may be an inclination to paraphilia or atypical gender identity in the offspring of a paraphiliac parent. In one study of boys displaying femininity (considered at risk for atypical gender development, including transvestism), of a sample of 20, two fathers were transvestites, and two mothers were lesbians. However, it might also be argued on the basis of the same data that some hereditary factor might be at play. Psychoanalysts and psychotherapists have observed that sadistic patients often report that their parents were brutal or sadistic, whereas masochistic patients may report that their parents were sadistic or masochistic. The child may identify with a sadistic or masochistic parent or may eroticize being abused.

### Developmental Adversity and the Offender as Victim

Some psychoanalysts and psychotherapists have suggested that a spectrum of early experiences is common in the histories of patients with particular paraphilias and that they appear to be symbolically or actually reenacted in the perverse fantasy. For example, the transvestic fetishist sometimes gives a history in which his mother dressed him in girls' clothes when he was a child, and the sadist gives a history that he was beaten. However, the question has not been settled as to whether such histories reflect real events, retrospective and unconscious falsification, or childhood misperception.

It has been observed that, among those paraphilias that constitute sexual abuse, as much as 30 percent of the paraphiliacs may themselves have been victims of sexual abuse before they were 18 years of age. The mechanism by which a victim becomes an abuser is understood as identification with the aggressor, that is, reliving a trauma but placing oneself in the power position.

**Psychogenic Origin** It is possible to reconstruct the psychodynamics in some paraphiliac patients and to assess the role of early childhood experiences in the construction of the perverse fantasy. Although psychodynamic formulations are crucial to understanding the structure and meaning of the perverse fantasy, they do not, in and of themselves, establish etiology.

Freud originally postulated that neuroses and perversions were inversely related, with neuroses representing symbolic displacement from perverse fixations, whereas perversions were direct expressions of preoedipal psychosexual fixations. Most psychoanalysts have revised this early formulation and now regard perversion, too, as a defensive compromise.

Psychoanalysts also believed that perversion in the man primarily served as a defense against castration anxiety by symbolizing an illusory female phallus. The fetish was viewed as the prototypical perversion and was literally equated with the illusory female phallus. It was thought to deny the sexual distinction and, thereby, the fear of castration anxiety. Freud made no effort to explain why castration anxiety sometimes led to perversion and, at other times, to homosexuality but most commonly was resolved with no untoward influence.

By and large, the hypothesis that the fetish is an illusory female phallus has become much less influential. More recent formulations have addressed the sources of any disposition to intensified castration anxiety, and, consequently, they have focused on factors occurring early in development. Prob-

lems in the separation-individuation phase seem to form the matrix within which perverse formation becomes more likely. Such problems include the development of a poorly defined and unstable body image and the twin fears of engulfment and abandonment by the mother, usually with some oscillation between them. As a defensive maneuver against separation anxiety, it is theorized that the boy invokes a compensatory identification with his mother. The sight of the maternal genital then becomes frightening, because it serves to emphasize the difference between the boy and his mother. At the same time, the feminine identification leaves him vulnerable to an exaggerated threat of castration anxiety in the oedipal period, because he already doubts his masculinity. In this formulation, the fetish is sometimes viewed as a bridge to the mother (a symbolic representation of her) that allays separation anxiety, rather than as a representation of the female phallus.

In addition to anxiety and preoedipal conflicts with the mother as codeterminants of perversion, analysts have emphasized the central role of aggression in erotic excitement. Some analysts have remarked on the transformation of dependent relationships into aggressively destructive ones. Undoubtedly, the dispositions of aggression and power in early developmental life enter into the genesis of paraphilias. This is explicit in sadomasochism. Interviews with sadomasochists show how much they focus on assuming control or giving it away. Paradoxically, masochists may find a feeling of control in submission, something generally acknowledged in the sadomasochistic community in which it is the convention that bottom rules. Others describe masochism as freedom from the demands of the ego. Power is clearly an issue in dominance, which is manifest by the impulse to exert complete control over another's reality. Paradoxically, then, both the masochist and the sadist can achieve a sense of power in the sadomasochistic encounter. These power issues are the residue of conflicts encountered between parent and child, as the child attempts to achieve a sense of agency and independence that mandates the overthrow of parental authority.

To date, no psychodynamic formulation fully addresses the question of why one particular perverse fantasy is selected. The perverse fantasy or act is frequently described as a scenario in which the perverse script symbolizes the sexualization of and triumph over a real or imagined trauma of childhood. Thus, the perversion is believed to undo an actual trauma from an early childhood period, often using real life occurrences as its narrative structure. Sometimes it appears to be an identification or counteridentification with a parent.

There is general agreement among psychoanalysts that the function of the paraphilia often goes beyond the facilitation of sexual potency. It may stabilize personality, in helping to patch over flaws in reality testing or in warding off psychoses. Aggressive wishes, deriving from the traumatic experiences of the preoedipal period, are bound and controlled in the perverse structure. Some authors may go too far in emphasizing how playful, imaginative, and creative the perverse solution is. They ignore the fact that the various perversions are not original creations but are stereotypical and constricting solutions to intrapsychic problems that frequently limit ego development.

## DIAGNOSIS AND CLINICAL FEATURES

The term *paraphilia* denotes the presence of an obligatory behavior or fantasy that is deviant in respect to the *object* of the sexual instinct or its *aim*. DSM-IV-TR emphasizes that the use of perverse sexual imagery and acts must be unusual or bizarre:

The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other nonconsenting persons, that occur over a period of at least 6 months (Criterion A). For some individuals, paraphiliac fantasies or stimuli are obligatory for erotic



arousal and are always included in sexual activity. In other cases, the paraphiliac preferences occur only episodically (e.g., perhaps during periods of stress), whereas at other times, the person is able to function sexually without paraphiliac fantasies or stimuli. The behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B).

Accurate diagnosis depends on eliciting the paraphiliac fantasy and ritualized behavior. To make the diagnosis, the achievement of sexual excitement must be dependent on the mental elaboration or behavioral enactment of the deviant fantasy.

The diagnosis of the specific paraphilia depends on the nature of the deviant fantasy, imagery, and behavior. The overt clinical syndrome most often begins shortly after puberty and follows a chronic course. In the paraphilias, by definition, the deviant fantasy and behavior must be the precondition for orgasmic discharge. Therefore, it is obvious that the diagnosis can only be made in adolescence or later. Even though there is evidence for antecedent psychological maladjustments or affective discomfort during childhood, these are not specific to or pathognomonic for the paraphilia and are therefore not predictive. For example, although most transvestites engaged in cross-dressing in childhood, not all cross-dressing boys grow up to be transvestites.

Each of the subclassifications of paraphilias or any specific paraphilia is distinguished by its central imagery and fantasy. Although many individuals who have paraphilias favor one single paraphilia, many are *polymorphous perverse*, that is, they engage in more than one paraphilia.

Although there are many theories that attempt to explain the meaning of each perversion, the following sections are limited to an exposition of the clinical features that are descriptive of each. Their symbolic meanings were alluded to in the section on etiology.

**Exhibitionism** Table 18.2-1 lists the DSM-IV-TR diagnostic criteria for exhibitionism. In men, sexual arousal is produced by exposure of the genitals to an unknown woman or girl, usually in a public place. It is the experience of the exhibitionistic urge as an irresistible impulse that defines it as pathological. The exhibitionist often, but not always, masturbates as part of his exposure. Exhibitionism, identified in the law as *indecent exposure*, counts for approximately one-third of the sexual offenses in the English-speaking world. As much as 30 or 40 percent of women may have been exposed to exhibitionism. Sexologists sometimes refer to these women as *victims*.

Exhibitionism is primarily reported in men, some of whom may be married and have regular sexual contact with their wives. Obscene phone calls accompanied by masturbation, as a sexual outlet, constitute a related perversion. In fact, exhibitionism, voyeurism, and telephone scatologia are frequently combined.

**Table 18.2-1**  
**DSM-IV-TR Diagnostic Criteria for Exhibitionism**

- A. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger.
- B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000, with permission.



**Table 18.2-2**  
**DSM-IV-TR Diagnostic Criteria for Fetishism**

- A. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments).
- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in transvestic fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator).

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000, with permission.

Occasionally, women are flashers. For example, a woman may go out wearing only a raincoat and open it to expose herself. Here, however, the thrill is often reported as a sense of exposure accompanied by humiliation and is not invariably accompanied by sexual arousal.

**Fetishism** In the case of fetishism, an inanimate object (e.g., a shoe or a handkerchief) or a part-object (e.g., a foot or a partner wearing high-heeled shoes) is required for sexual arousal (Table 18.2-2). The fetish may itself be the only object of sexual interest, in which case, genital discharge is achieved through masturbation, or, alternatively, the fetish may be incorporated into sexual activity with a partner who embodies or wears the fetish. Fetishes often have particular textural characteristics, for example, rubber, leather, and velvet are favored fetishistic materials. The fetish is most commonly associated in some way with humans or their bodily adornments, not something so far removed as furnishings or impersonal belongings. Although some fetishists favor a single fetish, others favor a small variety of objects. A particular fetish or group of fetishes is generally favored for long periods of time. One hospitalized patient favored urinals as his fetishistic object, but he was clearly in the psychotic range, and his perversion, as such, merged with the excretory perversions.

Fetishism has been reported only in men, homosexual and heterosexual, and often exists in combination with other perversions. For example, some transvestites are easily aroused by wearing tightly bound rubber underpants or prefer leather clothing.

Occasionally, women report being a victim of a fetishistic impulse. One woman vividly remembers riding in the subway, sitting next to a man who reached over and took the fabric of her skirt between his two fingers, raised it off her knee, and lowered it without ever making contact with her actual flesh. She said nothing, and he soon got off the train. (His behavior might also be considered kin to frotteurism.)

**Frotteurism** *Frotteurism* is defined by fantasies and impulses to touch or to rub against an unconsenting female (Table 18.2-3). The full-blown perversion involves a man positioning himself next to a woman in a crowded situation (for example, the subway or bus) to take advantage of the crowding and the movement to rub his genitals against her crotch, thighs, buttocks, or some other body part. Some frotteurists may fantasize that this constitutes a consenting sexual encounter. One sexologist proposed the term *toucherism* to refer to a man's touching a woman on her breasts or buttocks. In a clinical practice, one hears about as much about frotteurism from the female object as from the perpetrator. A woman may be stunned when a strange man passes her on the street, reaches out, touches her

**Table 18.2-3**  
**DSM-IV-TR Diagnostic Criteria for Frotteurism**

- A. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person.
- B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000, with permission.

breast, and keeps on moving. She may find this sufficiently disturbing that it triggers an anxiety reaction.

**Pedophilia** To make the diagnosis of pedophilia, the patient's preferred route to sexual excitement must be fantasied or enacted sex with prepubescent children. There must be an age differential of at least 5 years between the perpetrator and the victim (Table 18.2-4). The activity includes exposure of genitals, masturbation with or without the child's awareness or participation, manual manipulation of the child, oral or anal contact, or penetration. The pedophile may seduce, bribe, or coerce the child into masturbating or otherwise pleasuring him. The enactment may take place with an unknown child but may also occur within the home. Pedophilia is differentiated through specifying which gender the perpetrator prefers (male or female, or both), his relationship to the victim (incestuous or non-incestuous), and whether the sexual pattern is obligatory, that is, whether the pedophile is attracted exclusively to children or may be able to have other sexual contacts as well. In one study, heterosexual molesters (nonincestuous) reported an average of 20 victims, whereas homosexual child molesters (nonincestuous) had an average of 150 offenses. Pedophilia has been reported in heterosexual and homosexual men, more frequently among heterosexuals. However, it is not clear whether this is simply because there are more heterosexual males. Occasionally, a woman is a pedophile. Psychotic distortions of the pedophilic urge may be enacted: One father maneuvered his infant daughter to nurse on his penis; a woman became excited by biting her daughter's vagina. Although this woman was disturbed by her behavior, she experienced it as a compulsion that she was unable to control.

A distinction needs to be made between the pedophile, on the one hand, and the child molester, on the other hand. Pedophiles prefer children as their sexual partners. Child molesters are motivated not by preference but by the unavailability of another adult or by the use of some substance that disinhibits control. For the child molester, his sexual preference is not sex with children, and he targets children simply because of convenience. Some studies show that more than one-half of child molesters were themselves victims of sexual abuse during their childhoods. Some rationalize their behavior by a belief that it may be good for the child, that the child enjoys it, or, at the very least, that the child is not troubled by it. Frequently overlooked is hebephilia, which targets young adolescents rather than children.

**Sexual Masochism** Table 18.2-5 presents the diagnostic criteria for sexual masochism. The masochist fantasizes being humiliated, beaten, bound, or made to suffer and has impulses to enact these fantasies. Some women like to fantasize about being hookers and being paid to do whatever humiliating behavior is required. Although some masochists may fantasize about being tortured, only a few fantasize about being mutilated or killed. Masochistic elabora-

**Table 18.2-4**  
**DSM-IV-TR Diagnostic Criteria for Pedophilia**

- A. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally 13 years of age or younger).
- B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
- C. The person is at least 16 years of age and at least 5 years older than the child or children in Criterion A.

**Note:** Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

**Specify if:**

- Sexually attracted to males
- Sexually attracted to females
- Sexually attracted to both

**Specify if:**

Limited to incest

**Specify type:**

- Exclusive type (attracted only to children)
- Nonexclusive type

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000, with permission.

tions of other paraphilias are common; for example, the erotic preference for being straddled and urinated on combines an excretory and masochistic perversion.

**Sexual Sadism** Sexual sadism is in some ways a mirror image of sexual masochism. It consists of sexual fantasies and urges that involve the infliction of psychological or physical suffering, or both, on a partner (Table 18.2-6). Fantasies and enactments include verbal and physical humiliation, bondage, forceful restraint, and spanking and, at the extreme, may include torture, mutilation, and killing. The partner's involvement may be fully consenting (as is the case in ongoing sadomasochistic relationships), or the partner may exhibit a complete lack of consent (as sometimes can occur in violent initial sexual encounters).

Masochism and sadism are distinguished from the other paraphilias in two ways and are therefore of special interest. First, although, like the other paraphilias, they occur among heterosexuals and homosexuals, they are the only paraphilias that occur in large numbers in both genders. Second, they merge more perceptibly into aspects of normal sexuality. Indeed, in DSM-III, it was suggested that "the diagnosis of sexual masochism is made only if the individual engages in masochistic sexual acts, not merely fantasies." This

**Table 18.2-5**  
**DSM-IV-TR Diagnostic Criteria for Sexual Masochism**

- A. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.
- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000, with permission.



**Table 18.2-6**  
**DSM-IV-TR Diagnostic Criteria for Sexual Sadism**

- A. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.
- B. The person has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000, with permission.

exemption is not applied to the other paraphilias, including sadism. This may be indicative of how widespread masochistic fantasies are and certainly suggests that the border between normal and deviant may be porous.

Beginning with Freud, it has been recognized that masochism and sadism are often linked, that is, that although an individual is usually preferentially a sexual masochist or sadist, he or she can occasionally enact the other role. These observations suggest that the masochist and sadist often identify with the sadomasochism transaction, not exclusively with one role. Some psychiatrists prefer the term *sadomasochism*, rather than *sadism* and *masochism* separately, to make the point that pure sadism is generally laced with masochism, and pure masochism is laced with sadism.

It is unusual to see any patient whose sexual life is predominantly sadistic or masochistic who does not enact some form of sadomasochism in the nonsexual arena. Sadomasochism is particularly complicated, because it can be embedded in the overlapping spheres of the sexual and the relational. In the sexual situation, aggression in the form of controlled sadism or masochism can be experienced as pleasurable, but this is far less true in the case of relational sadomasochism, particularly for battered wives.

In some individuals, the need for sadistic behavior escalates and may result in sadistic rape, lust murder, or serial murders. Far more common, however, is the clinical finding that sadistic men may inhibit themselves sexually, because they are reluctant to engage in those enactments that are requisite to arousal, particularly with their wives. These individuals give up sexuality rather than run the risk of indulging the fantasy or the behavior or seek out prostitutes. It might be argued that those who do not engage in any sadistic behavior and who suppress the fantasy, when possible, are not perverse. However, in terms of personality organization and preoccupation, they are close psychological kin to sadists who exhibit the overt syndrome.

Although it is commonly believed that masochism predominates among women, the reports of gender ratios vary considerably. For example, almost all of Krafft-Ebing's reported cases were in men. Curiously enough, Freud derived the concept of feminine masochism from analyzing the masochistic perversion in men. The enacted fantasy may well be more common in men, although it is still an open question as to whether obligatory masochistic fantasies predominate in one gender or the other.

Common is the sexual sadomasochist who is sadistic in one relationship and masochistic in another (or dismissive in one, yearning in the other), reprising Arthur Schnitzler's famous play, *La Ronde*. Mr. B., a successful 45-year-old businessman, splits his emotional life between a wife whom he oppresses and his assistant, Ms. J., with whom he is enthralled and whom he placates moment to moment. When Ms. J. tells him she is involved with a younger man, one who

works in a position subservient to her, Mr. B. suffers, but his sexual desire for her explodes. The minute that she is out of his sight, he begins to obsess in a kind of masochistic perseveration about whether she is at that moment sleeping with the other man. Mr. B. holds a dominant position in the business world, but, in his psychic world, he is under the spell of Ms. J. In his sexual life, he will do whatever is demanded of him, including limiting his own preferences, to please her. He allows himself to experience orgasm only with her consent. In contrast, he dominates and humiliates his wife. His cruelty towards her is expressed in his reluctance to sleep with her, in his emotional coldness toward her, and in sadism on the rare occasions when he sleeps with her out of sexual need or out of anger that Ms. J. is with another man. Then he slaps her around. Even when he is not sexually abusive, he verbally expresses contempt for her body and her erotic skills. The more he feels humiliated by Ms. J., the more he humiliates his wife. This kind of split appears to be an enactment of a split relationship with one or another parent. Mr. B.'s angry dominating stance toward his wife appears to be a derivative of the rage he felt toward his neglectful mother; he now wishes to dominate and to humiliate his wife, just as he felt his mother had done to him. In parallel, his subordination to Ms. J. appears to echo the intermittent but abject longing for his mother's love, which he experienced in childhood, but which was forthcoming only in brief moments.

**Transvestic Fetishism** *Transvestic fetishism* literally means cross-dressing. In psychiatry, however, the term was used not only phenomenologically, but also diagnostically. It was defined as heterosexual cross-dressing in which pieces of clothing were used fetishistically for sexual arousal. Because of the fetishistic component, the term *transvestic fetishism* has come to be substituted for the term *transvestite*. The cross-dressing may be used to promote sexual excitement that can lead to masturbation or heterosexual intercourse. Although the cross-dressing may begin in childhood, it usually becomes sexualized only in adolescence. In the predominant pattern, the child spontaneously cross-dresses, using the garments of his mother or sister, and the activity most often remains surreptitious. In some instances, it is reported to have been initiated by the mother or mother surrogate. Cross-dressing can start with a desire to promote a sense of self-soothing and well-being and then becomes sexualized, or it can be erotic from the outset. It is sporadic at first and, in most transvestic fetishists, remains so. In some, however, it becomes a daily occurrence. Table 18.2-7 lists the DSM-IV-TR diagnostic criteria for transvestic fetishism.



**Table 18.2-7**  
**DSM-IV-TR Diagnostic Criteria for Transvestic Fetishism**

- A. Over a period of at least 6 months, in a heterosexual man, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.
- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

**With gender dysphoria:** if the person has persistent discomfort with gender role or identity.

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000, with permission.

Transvestic fetishists are, by definition, preferential heterosexuals. Fetishistic arousal can be intense, but interpersonal sexuality is almost always attenuated. It is typical for a transvestic fetishist to report his entire sexual experience as limited to one or two partners. In adulthood, his behavior may be masculine in male clothes, effeminate in female clothes. Many are employed in hypermasculine professions (e.g., race care driving, munitions experts). Some transvestic fetishists carry photographs of themselves dressed as women; others habitually wear hidden female undergarments. These are mini symbols of cross-dressing and enhance the illusion of being a woman even while dressed as a man.

In the pornography favored by transvestic fetishists, the initiation into cross-dressing is usually forced on the novice by a dominant, big-breasted, corseted, booted, phallic woman who enslaves him or by a kindly protective woman who does so to save his life. Such initiation fantasies permeate the collective fantasy life of transvestic fetishists.

Some transvestic fetishists fall in love with transsexuals and, as a consequence, give up cross-dressing altogether. This relationship appears to be based on projective identification; that is, the transvestic fetishist projects his fantasy of being female onto the transsexual and then reincorporates it by identifying with "her."

Mr. H. is 46-year-old married transvestic fetishist, a successful lawyer who loves his work. He and his wife have two grown children, who no longer live at home. Ambitious and competitive, he masks his aggression behind a gentle façade. He views himself as helpful to other people and is proud of his ability to assert himself when necessary.

Mr. H. was the youngest of two siblings with a sister who was 3 years older. His parents had a tempestuous marriage and, after multiple separations, ultimately divorced when Mr. H. was 7 years of age. During the separations, and after the divorce, he and his sister stayed with their maternal grandparents. Mr. H. was living with them on a consistent basis even before his parents finally divorced. He saw his mother only irregularly. He has obliterated all memory of his father. His mother was outgoing and loving to Mr. H. when she saw him, but, with each separation, he feared he might never see her again and was overwhelmed with sadness. As he grew older, his grandparents left him on his own. He would disappear and stay with friends for several days, and no one questioned why. Although he sometimes recounts this as a positive experience, the fact is that he felt abandoned throughout childhood, commenting that he largely raised himself. He was never effeminate, and he never played with girls. He was a good student, and, after college, he went to law school.

His aunt's ministrations were tender and, at times, seductive. She fondled him, combed his hair, and rubbed him down with oil. He remembers an early attachment to her mohair blankets but denies that she ever cross-dressed him. He began to cross-dress in his aunt's clothes at 8 years of age. It was always in secret, and he was never discovered. Cross-dressing was initially nonerotic and produced a safe form of relaxation—like alcohol. Only in adolescence did he begin to eroticize female clothing and to have spontaneous ejaculations while cross-dressed. In his late teens, he had sexual intercourse for the first time with an older female neighbor whom he married while he was still in his early 20s.

His cross-dressing escalated after the birth of his first child. At the same time, his sexual drive toward his wife began to diminish. He continues to have an increasing urge to cross-dress under stress. He entered treatment, because the cross-dressing preoccupied him more and more, and his wife was threatening divorce in response to his loss of sexual interest in her. Like many other transvestic fetishists, he continues to have a pronounced interest in masculine activities.



**Table 18.2-8**  
**DSM-IV-TR Diagnostic Criteria for Voyeurism**

- A. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, who is in the process of disrobing, or who is engaging in sexual activity.
- B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

From American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Text rev. Washington, DC: American Psychiatric Association; 2000, with permission.

**Voyeurism** *Voyeurism* is defined as a preference for masturbating while observing nude women who are unaware of being seen (Table 18.2-8). Men may achieve sexual arousal by looking at strange women in situations that they construe as sexual (e.g., spying on a woman who is undressing—the proverbial Peeping Tom). Voyeurs do not otherwise accost the women observed. Excitement may sometimes be purely psychic. Voyeurism has been reported only in men, and it often takes priority over any wish for sexual intercourse.

Voyeurism may be one of the least researched forms of paraphilia. It has been reported that the voyeur seeks no sexual contact with the victim, yet, in one study, one-third of the subjects had committed rape. A number of voyeurs are married but nonetheless have fears of approaching women sexually.

One man, best described as polymorphous perverse, spent the early years of his marriage avoiding sex with his wife while sneaking glances of a woman across the courtyard dressing and undressing. This man, like many other voyeurs, had a number of coexisting paraphilias; he preferred watching his spouse insert the tube of an enema bag into her vagina, so as to masturbate rather than having intercourse with her. He associated this preference to having once seen his mother naked in her bathroom, holding a douche bag or an enema bag. In his therapy sessions, he frequently closed his eyes. He eventually disclosed that, during such moments, he had flash fantasies in which he visualized women in a number of erotic poses.

**Paraphilias Not Otherwise Specified** Paraphilias not otherwise specified include telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of the body), coprophilia (feces), klismaphilia (enemas), and urophilia (urine). Although sporadic sexual relationships with animals can be elicited by history, it is rare that this is the preferential route of sexual discharge. Some authors distinguish zoophilia (sexual excitement experienced with stroking or fondling animals) from bestiality (a sex act between an individual and an animal).

## LABORATORY EXAMINATION

The penile plethysmograph is used as a diagnostic parameter, and it may also be used in some desensitization therapies. Its therapeutic use is discussed in the section on therapy. As a diagnostic tool, it helps delineate paraphiliac response by measuring penile volume assessment or penile circumference (the newer measure) in response to suggestive films of sexual scenes. Originally used to identify compulsive homosexuality, it was later applied to paraphiliacs. Although it was initially thought that penile circumference assessments would have results comparable to those of penile volume assessment, this may not be the case.

The difference in the two procedures is in the length of the subjects' exposure to sexual films. With the earlier technology, exposure was for the duration of only 10 to 13 seconds. The newer technology uses 2-minute video clips. The issue is whether with the newer technology—penile circumference—the test result can be faked or is resistant to faking. Penile circumference assessment inevitably requires longer exposure to erotic stimuli, because the blood flow that accompanies penile tumescence cannot maintain penile circumference while maintaining the rapid increase in penile length. The longer time needed to assess circumference may allow the subject to suppress his response to the erotic material being shown; that is, he can fool the researcher. The questions raised about the validity of this test have importance insofar as it is used in outcome studies to measure change after therapy with sex offenders, including, for example, pedophiles.

## DIFFERENTIAL DIAGNOSIS

Differential diagnosis is usually relatively easy. Occasionally, there is some confusion between paraphilias and the gender identity disorders or psychoses.

### Characteristics Essential to the Diagnosis of Paraphilia

The following features are essential to the diagnosis of the paraphilias and are common to them all.

- ▶ The deviation appears fixed. Unusual fantasies or behaviors are persistent and repetitive and permeate mental life. They are ritualized and stereotypical.
- ▶ The deviant fantasy must have been pervasive for the preceding 6 months, or the impulse must be imperative and insistent.
- ▶ Perverse behavior generally occurs in two distinct phases. The perverse activity is usually followed by a heterosexual or homosexual encounter or by masturbation. Sexual excitement and potency appear to be facilitated by the preceding perverse behavior. Therefore, most perverse behavior terminates with genital orgasm. It must be emphasized that neither the perverse behavior nor the sexual act necessarily requires another person. For example, transvestism and fetishism are considered perversions, even when the deviant activity is solitary, and the genital activity is masturbation.
- ▶ The deviation may be ego-syntonic or ego-dystonic. When the individual is under the pressure of seeking orgasmic release, it is most often experienced as ego-syntonic. However, there may be a marked ego-dystonic reaction after the enactment of the perverse activity. There may also be long periods in which the individual makes the attempt to disavow the perverse fantasy and enactment.
- ▶ Suppression of the perverse fantasy becomes difficult, if not impossible. Enactment is often triggered by anxiety or some other dysphoric emotion. After the fantasy is enacted, it sometimes results in depression, the feeling of profound emptiness, or the reemergence of anxiety.

The question arises as to whether the presence of pervasive perverse fantasies that are not enacted is adequate for the diagnosis of paraphilias. DSM-IV-TR suggests that it is. Thus, although the behavioral manifestations of sexuality may appear normal, the patients are aware of, if not alarmed by, the obligatory and sometimes obsessive nature of their fantasy lives. However, if the perverse fantasies are incidental or occasional, they can be understood as part of normal sexuality and not of decisive psychological significance.

### Features Commonly Associated with the Paraphilias

Although some characteristics are common to all the paraphilias, individual cases vary in terms of personality integration, associated pathology, and overall adaptation.

- ▶ Some married individuals enact the paraphilia only outside of the marital sexual situation, although the perverse fantasy may fuel the marital sexual encounter. Excitement is invariably greater with the deviant enactment.
- ▶ In some instances, the perverse activity tends to escalate over time. This seems particularly true of transvestic fetishism and, perhaps, sadomasochism.
- ▶ Aside from the paraphiliac fantasy, which is obsessive and intrusive in nature, there is a diminution in other kinds of sexual fantasies and in nonsexual fantasies. Dreaming is sometimes scant.
- ▶ Patients may regard their behavior as essentially normal, although they know that their preferences are unusual. Despite their claims of normality, they often feel humiliation, guilt, shame, and fear of legal entanglement. Insofar as they wish to suppress their perverse behaviors, they experience dysphoric affects, if they are successful, and a feeling of lack of control, if they are not.
- ▶ Paraphilias are not invariably mutually exclusive. For example, one may see combinations of transvestism and sexual masochism. The paraphilias frequently coexist with sexual dysfunctions.
- ▶ Although perversion may be associated with a borderline personality organization, most contemporary therapists and sexologists observe that paraphilias may have higher or lower levels of personality integration. In the higher levels of integration, the perversion serves primarily to facilitate sexual functioning. It is among these individuals that perverse fantasies, rather than enactments, may suffice to facilitate potency. In the lower ranges of integration, the paraphilia is not only used to promote pleasurable sexual function, but also to maintain ego boundaries and the sense of self and to bind aggression.
- ▶ The nature of the paraphilia is not indicative of the level of personality integration. Sometimes, it has been assumed that certain paraphilias must be associated intrinsically with greater ego disturbance than others; for example, some observers have suggested that, to the extent that the object is a part-object or denigrated, the overall personality is more primitive. Yet, this is not necessarily so. Each syndrome comprises individuals exhibiting a wide diversity of personality integrations.
- ▶ Although the DSM-IV-TR calls attention to the fact that there is often impairment in the capacity for reciprocal affectionate sexual activity, this is variable. Within the higher levels of personality organization, the individual is more often able to achieve reciprocal affectionate sexual relationships, sometimes of a dependent nature, and to maintain meaningful nonsexual relations.
- ▶ Paraphiliacs are depression prone: The depression often takes the form of an ongoing empty depression. Alcoholism or drug addiction is widely observed and may represent a maladaptive attempt at self-medication of the depression.
- ▶ Perverse behavior often entails interpersonal complications that themselves become the source of depression and anxiety; for example, it may be the source of discord in a marriage and may lead the paraphiliac to enter into other relationships, with a more tolerant girlfriend or with a prostitute. Perverse behaviors with nonconsenting individuals may lead to legal entanglements.

### Disorders That Are Sometimes Confused with the Paraphilias

Although some transvestic fetishists use cross-dressing almost exclusively to achieve sexual excitement, nevertheless, there are also a significant number of transvestic fetishists for whom the purpose of cross-dressing evolves or changes over time. In this latter group, the cross-dressing becomes the purpose in and of itself, to assuage anxiety and to assert a partial female gender identity; its importance as a prerequisite to sexual arousal takes second place to the increasing urgency to self-identify as a woman. DSM-

IV-TR takes no account of the frequent evolution of transvestic fetishists into transsexuals. In fact, transvestic fetishists are one of three diagnostic entities that feed into the transsexual diagnosis. (The other two consist of cross-dressing homosexuals and primary transsexuals.) Although DSM-IV-TR attempts to address differences in transvestic fetishists by suggesting that the diagnosis specify if the transvestic fetishism is accompanied by gender dysphoria, it is important to emphasize that, in many cases, there is a metamorphosis, such that the primary emphasis becomes sex change rather than the facilitation of a sex act.

The gender identity disorders are distinguished by an impairment of core gender. It is not altogether clear why transsexualism and cross-gender identifications in children are classified as identity disorders, whereas transvestic fetishism is grouped with the paraphilias.

In some patients, an obsessive sexual fantasy in an otherwise neurotic patient may mimic a paraphilia. Although perverse fantasies may surface in the course of an in-depth psychotherapy, they do not invade conscious life to the same degree as in the paraphilias nor are such obsessive fantasies necessarily associated with any preemptive urge to enact the fantasy.

Certain behaviors are classified as paraphilias by some experts but not by others. The most confusing category may involve sexual acts that infringe on the welfare of others. For example, sexual assault, which, along with child molestation, may commonly result in imprisonment, is not classified as paraphilia. Although some clinicians consider rape to be paraphilia, most do not. For most rapists, rape is neither the preferred sexual activity nor a consistent fantasy preoccupation, and these remain the hallmarks requisite to the diagnosis of a paraphilia. It is true that rape perpetrated against enemy women in war time or in gang rapes is far different from the psychologically driven sexual enactments classified as paraphilias. In contrast, serial rapists are often acting out some powerful impulse or fantasy. Part of the problem in labeling compulsive rapists as paraphiliacs may be a legal one; that is, if something is diagnosed as a paraphilia, such a psychological or medical diagnosis might protect the perpetrator against criminal action. However, this is not the case with pedophilia. As previously noted, a related problem is the question of whether a distinction should be made between paraphilias that inflict harm and those that do not.

Homosexuality was declassified as a paraphilia in the context of gay liberation. The declassification was warranted because of the following compelling reasons. First, the central imagery of homosexuals is not generally bizarre. Second, the homosexual impulse, like the heterosexual one (but unlike the deviant one), may not be driven. Third, homosexual behavior need not be ritualized or stereotypical in the way that the paraphilias invariably are. Fourth, fantasy life is not impoverished. Fifth, and most importantly, it has not been demonstrated that homosexual ideation invariably permeates mental life to an excessive degree, that the suppression of any one homosexual act yields high-level anxiety or dysphoric affect, or that homosexuality is connected to personality dysfunction any more than heterosexuality is. However, homosexuals are no more immune from paraphilias than are heterosexuals. Homosexuality and paraphilias may coexist just as heterosexuality and paraphilia coexist.

## COURSE AND PROGNOSIS

The sexual fantasies that are at the core of the paraphilias generally begin to take shape in childhood but are elaborated and become more precise throughout adolescence and early adulthood. Although many paraphiliacs revise and edit their fantasies throughout their lifetimes, some rotate between a few favorite paraphiliac fantasies. The pressure

to enactment varies over time, usually increasing at times of external stress. To the degree that opportunities to enact the paraphilia present themselves, interest in it may grow. For some people, the paraphilias decline with age and a decreased interest in sexuality.

The frequency and intensity of paraphiliac fantasies and enactments increase in proportion to involvement in networks of people similarly inclined. For example, in transvestic fetishism, the man uses a piece of female clothing or dresses in female clothes to facilitate sexual arousal and masturbation. Immersion in a transvestic subculture, an activity first facilitated through magazines such as *Transvestia*, generally promotes an evolution in intensity. Insofar as a transvestic fetishist is involved in a subculture, his cross-dressing tends to escalate. Immersion in such a subculture normalizes the behavior and appears to reduce some of the internal resistance to compulsive dressing.

Whenever there is communication among people who share the same paraphilia, the usual outcome is to normalize the paraphilia and thereby to increase the individual's likelihood of enacting it. The Internet provides virtual groups that have the same effect.

Because the preconditions for the paraphilia—whether they are biological or psychological—are laid down so early in the paraphiliac's life, they become part of his or her identity and the source of sexual pleasure. Paraphilias, like all behaviors that yield pleasure, are difficult to relinquish. This is more so for the paraphilias than for, say, smoking or drinking, because the paraphiliac fantasy is so closely woven into the paraphiliac's identity and sense of self. At the same time, paraphiliacs often feel shame or are disturbed by the compulsive nature of their sexuality and may make the attempt to give up the paraphiliac behavior. This is generally successful for only a short period of time, so that psychiatrists who follow their patients for a number of years observe cycles of activity and inactivity—of pleasure in the paraphilia and revulsion toward it. During one of the cycles of inactivity, the paraphiliac patient may feel that he or she has conquered the problem but nonetheless remains susceptible to its reoccurrence, particularly during times of stress. Clinicians, too, may be prematurely seduced into believing that they have secured a cure. Some researchers may display the same naïveté, confusing cycles of renunciation with permanent cure.

## TREATMENT

Treatment is extremely difficult, because the symptom yields pleasure and, as a consequence, is hard to relinquish. Renunciation may be even more difficult when the paraphilias are associated with a borderline personality. Patients with paraphilias are subject to many kinds of secondary crises, including depressions. Although the treatment of paraphilia itself is invariably difficult, the secondary crises can be successfully treated by a variety of means.

At least three different kinds of psychiatric modalities are used to assist the paraphilia patient in establishing internal control over the enactment of a paraphiliac fantasy. These include cognitive-behavioral therapy and group therapy, often coupled with relapse prevention, medication to reduce sexual drive, and dynamic psychotherapy or psychoanalytic psychotherapy. Although there have been attempts to empirically evaluate the first two modes of therapy, outcome studies on patients treated by psychotherapists and psychoanalysts depend on the individual case reports of the therapist. However, there should be a disclaimer for the validity of follow-up studies, no matter what the mode of therapy. Relapse often occurs after the evaluations have been completed, particularly if evaluations are done within a short time after the treatment.

In those instances in which sexual victimization is part of the paraphiliac fantasy, the urgent need is not for any of the three treatment modalities, but for the establishment of external controls to prevent the victimization of others.

Finally, therapists need to treat comorbid conditions that affect the urgency of the paraphiliac fantasy and enactment.

The choice of treatment depends, in part, on the presumed etiology and on the urgency of controlling the enactment of potentially dangerous paraphilias. In reality, most paraphiliac enactments that entail a victim are designated as sex offenses, and the perpetrators receive cognitive-behavioral therapy or psychopharmacological treatment. Those who are self-referred and who seek individual treatment are more likely to receive dynamic psychotherapy and, sometimes, cognitive-behavioral therapy.

**Cognitive-Behavioral Therapy** Cognitive-behavioral therapy consists of direct, behavioral interventions rather than an exploration of the possible early developmental factors and interpersonal conflicts that may be part of the etiology. The behavior therapies aim to teach patients techniques that they can use to decrease deviant sexual urges and to maintain control of their behaviors. These include olfactory aversion, covert sensitization, various masturbatory reconditioning techniques, modified aversive behavioral rehearsal, and imaginal desensitization training. In covert sensitization, the patient is trained in relaxation. Once he is relaxed, he is asked to visualize his deviant behavior and then to introduce a negative event. For example, one expert suggested the following sequence: An exhibitionist is asked to picture himself in a car, exposing himself to school girls. As part of the story, he is asked to imagine calling the girls over to his car while he masturbates. It is then suggested to him that, as the girls are staring at him, he experiences a pain, the result of his penis getting stuck in his pants zipper. He is unable to yank it free, only hurting himself more. His penis starts to bleed, and he loses his erection. The girls are laughing, and a policeman is coming over. The resolution is that he is finally able to zip up his pants and drive off, whereon he begins to relax and to breathe more easily. The directed fantasy is structured in such a way that it starts with the build-up of deviant sexual arousal, which is interrupted by a negative consequence. The patient is able to escape only by renouncing his deviant stimulus. By introducing an adverse event into an established sexual scenario, it is hoped that deconditioning takes place. This and similar techniques may be carried out between therapist and patient in one-on-one therapy, or they may be implemented within a group format.

It has been suggested that different kinds of cognitive-behavioral treatments are more effective with different subgroups; for example, those that focus on relational problems may work relatively well with exhibitionists. However, even in treatments with the best outcomes, patients are vulnerable to relapse. Some patients may become lax out of wishful thinking that their cure is permanent. Therefore, part of the treatment should be concerned with relapse rehearsal.

Relapse therapy is a program designed to help the paraphiliac or offender become aware of danger signs and cope with them. Warning signals include the reappearance of the paraphiliac fantasies or decisions that may place him in a high-risk situation. Relapse rehearsal is exactly what the name suggests; the paraphiliac is asked to fantasize a relapse, to conjure up the negative feelings sometimes associated with it, including guilt, shame, and self-blame. He is encouraged to use those coping strategies and self-controls that he has already mastered, to visualize himself controlling the situation, rather than succumbing to it. The positive feelings that he conjures up in response to his successful handling of the situation reinforces

his feeling of self-control. Without such an intervention, recidivism rates may reach 55 percent. (Some observers would consider the recidivism rate to be much higher.) Outcome is sometimes assessed by means of a penile plethysmograph, in which a posttherapy patient is exposed to erotic stimuli known to have previously aroused him.

### Psychopharmacological Treatment to Reduce the Sexual Drives

Aversion therapy and treatment with antiandrogenic medication have been attempted with sex offenders and with paraphiliac patients. Sometimes called *chemical castration*, this misnomer may give the impression that treatment is definitive. Quite the contrary. Short-term control is easier to obtain than fundamental long-term change. Among the main antiandrogens used is cyproterone acetate (CPA), which acts on the androgen receptors to block intracellular testosterone intake and intracellular metabolism of androgen. Erections, ejaculates, and spermatogenesis are all decreased and, interestingly, so are sexual fantasies. Medroxyprogesterone acetate (MPA) has long been the leading drug studied in treating sexual offenders in North America. The principal action is through its stimulus to testosterone-A-reductase in the liver, which enhances the metabolic clearance of testosterone, thus reducing its plasma level. Its side effects include weight gain, decreased sperm production, and some gastrointestinal (GI) symptoms. Relapse generally follows the cessation of the medicine.

It is still debated whether paraphiliac behavior can be understood as part of the obsessive-compulsive spectrum of disorders. In this framework, the paraphiliac fantasies are considered to be to obsessions what paraphiliac enactments are to compulsions. In other words, the paraphilia is enacted when internal resistance is overwhelmed by the compulsion. It has been demonstrated that the same drugs that are effective in the treatment of some impulse control disorders, such as kleptomania, may have some effect in the paraphilias. These are drugs that are selective serotonin reuptake inhibitors (SSRIs). One advantage of this group of drugs is that they can be safely given to adolescents. None of the psychopharmacological treatments, however, constitutes a cure.

**Dynamic Psychotherapy** Although there are individual case reports of good results, there are no long-term follow-up studies and few large-scale studies. Not many psychotherapists would claim a high percentage of cure in patients with full-blown perverse syndromes. The patient's overall adaptation may well improve, but permanent change in the perverse structure is more problematical. The patient may learn how to identify situations that lead to increased anxiety or depression and to the escalation of paraphiliac fantasy and enactment, and he may learn how to avoid them. Outcome depends on the underlying personality organization. Insofar as the major function of the perversion is to facilitate sexual excitement more than to preserve the integrity of the ego, there is a greater opportunity for a successful treatment intervention. To the degree that borderline features are more prominent, the outcome is generally less favorable.

Some patients learn how to manage their lives so that perverse enactments are kept out of their intimate relationships. They may act out their perverse impulses with call girls or with willing extramarital partners. This, of course, only works with paraphilias that are nonthreatening to the welfare of their sexual partners.

**External Controls** External controls are indicated when paraphiliac behavior threatens sexual victimization of others. In the case of abuse within the family, adults other than the abuser and children must be protected by being instructed as to the danger. To the

degree that these constraints are ineffective, the offender must be removed from the home.

**Treatment of Comorbid Conditions** Various comorbid conditions may tilt a paraphilia toward escalating enactments. Chief among these are depressive reactions, loss of key relationships through divorce or death, loss of jobs or positions within the community, and self-medication with alcohol or recreational drugs. In addition, the paraphilias may be complicated by their coexistence with other psychological disorders: major depressive disorders, psychoses, or psychotic decompensation. When present, treatment for these conditions or counseling must become part of the treatment plan.

**Treatment Results** It is difficult to compare outcome results between the treatment of sex offenders (often including groups other than paraphiliacs) and the treatment of paraphiliacs seen in private practice. The two venues not only use different treatment modalities, but also deal with different patients.

The complaint against psychodynamically oriented clinicians is largely that there are few, if any, follow-up studies, and this is a valid criticism. In fact, as the following case demonstrates, analysts may believe that a patient is cured and may publish a case report to that effect, only to witness an exacerbation that goes far beyond the original problem.

A patient diagnosed as a transvestite (the terminology then used to describe what is now called a *transvestic fetishist*) engaged in a long psychoanalysis with a distinguished psychoanalyst, one of whose subspecialties was the paraphilias. The analyst well understood the patient's dynamics and worked through them with the patient. The patient married and had a child. At a certain point, the analyst came to believe that the patient's problems were resolved. This, of course, turned out to be a rather naïve assumption. In fact, several years later, the patient underwent a sex reassignment surgery and now lives full time as a woman. Such cases are cautionary tales. They show that the internal struggle between yielding to a paraphilia and resisting it can sometimes mislead psychotherapists and sexologists, who may mistake a pendulum swing to renunciation for a genuine resolution.

Nonetheless, psychodynamic treatment does provide considerable support to many paraphiliacs, particularly those who are not sex offenders. Therapists can intervene by addressing issues of stress and relational problems that may reduce anxiety within the home and by identifying those stresses that inevitably lead to an escalation of the paraphiliac impulse.

Unlike psychotherapy, which is conducted by therapists who generally see relatively few full-blown paraphiliac cases, cognitive-behavioral therapy, followed by relapse rehearsal and psychopharmacological treatment, has the advantage that some of its practitioners are immersed in the treatment of paraphiliacs under the auspices of programs to treat sex offenders.

The limitation to the treatment with antiandrogenic medications is the patient's noncompliance in continuing to take the medication. This limitation is a direct product of its mode of operation: It acts by reducing sexual desire and erections, not by selectively inhibiting deviant impulses. Over the course of months or years, patients may be unwilling to give up sexual pleasure. (An analogous problem is seen in some manic-depressives who stop taking their medication, because they are unwilling to forego manic bursts of energy.) Other reasons for noncompliance include side effects, such as weight gain, testicular atrophy, and hypertension.

Most of the investigators and therapists working with paraphiliac patients use some combination of cognitive-behavioral therapy

along with relapse prevention programs. It is believed that this is the most viable combination of treatment for paraphiliacs who have committed sex offenses. Many of these therapists formalize follow-up studies. Most of the follow-up studies show continuing improvement in the majority of treated patients for several years. Ultimately, the measure of success or failure is linked to rates of recidivism. The limitation to these follow-up studies is their duration; most of them do not follow the patients for a sufficiently long period of time, sometimes for just a few years. Given the nature of paraphilias, follow-up studies of only several years' duration are not good indicators of ultimate treatment outcomes. Because recidivism rates increase over time, long-term outcome studies are essential. Relapse rehearsal can be viewed as a mode of self-control. However, as several investigators have pointed out, this model does not focus on cure, but rather focuses on a prevention model of change.

Paraphilia needs to be viewed as a chronic condition that can be controlled rather than eradicated. In this context, stress management becomes an important component of any treatment plan. One can maintain some optimism, as long as the goal is control rather than cure, with the realization that results are much better if no sex offense is implicated, if there is a single paraphilia, if there is a stable home environment, and if the therapeutic relationship can be carried out consistently with the same person no matter what the modality of treatment. (Most reports stress that individual, rather than group, therapy is most beneficial.) That there seldom appears to be a cure should not discourage those in the field from seeking partial therapeutic success.

There are a good number of paraphiliac patients who have minor perversions and who live extremely productive lives. These are the paraphiliacs who seldom come to attention and whose paraphilias are contained within the boundaries of a relationship.

One often reads in the literature accounts of a successful and devoted pairing between individuals with complementary perversions. Therefore, there appear to be a number of self-described ongoing, gratifying relationships between sexual sadists and sexual masochists, some of whom extend sadomasochistic interactions to behaviors outside the sexual realm and who are known as *relational sadomasochists*. It is difficult to evaluate these claims, because these are the people who do not seek therapy. It does seem possible that sometimes consensual sadomasochistic relationships serve the needs of both people. Furthermore, minor perversions can be embraced within the context of an ongoing committed relationship.

## SUGGESTED CROSS-REFERENCES

Gender identity disorder is discussed in Section 18.3, personality disorders are discussed in Chapter 23, and sexual dysfunctions are discussed in Section 18.1a. The discussions of pervasive developmental disorders in Chapter 38 and separation anxiety disorders in children in Section 46.3 are also relevant. Child abuse is covered in Section 49.3.

## REFERENCES

- Abel GG, Hoffman J, Warberg B, Holland CL: Visual reaction time and plethysmography as measures of sexual interest in child molesters. *Sex Abuse J Res Treat.* 1998;10:81-95.
- Abel GG, Rouleau JL. The nature and extent of sexual assault. In: Marshall WL, Laws DL, Barbaree HA, eds. *Handbook of Sexual Assault: Issues, Theories, and Treatments of the Offender*. New York: Plenum Publishing; 1990.
- Bak R: Fetishism. *J Am Psychoanal Assoc.* 1953;1:285-298.
- Baker SW. Biological influences on human sex and gender. In: Stimpson CR, Person ES, eds. *Women: Sex and Sexuality*. Chicago: University of Chicago Press; 1980.
- Barbaree HE: Evaluating treatment efficacy with sexual offenders: The insensitivity of recidivism studies to treatment effects. *Sex Abuse J Res Treat.* 1997;9:111-128.
- Barbaree HE, Seto MC. Pedophilia assessment and treatment. In: Laws DR, Donohue WO, eds. *Sexual Deviance: Theory, Assessment and Treatment*. New York: Guilford Press; 1997.



- Bell AP, Weinberg MS. *Homosexuality: A Study of Diversity Among Men and Women*. New York: Simon and Schuster; 1978.
- Berlin FS, Abel GG, Levis DJ, Clancy J: Aversion therapy applied to taped sequence of deviant behavior in exhibitionism and other sexual deviations: A preliminary report. *J Behav Ther Exp Psychiatry*. 1970;1:59-66.
- Berlin FS, Meinecke CF: Treatment of sex offenders with antiandrogenic medication: Conceptualization, review of treatment modalities, and preliminary findings. *Am J Psychiatry*. 1981;138:601-607.
- \*Bradford JMW. Pharmacological treatment of the paraphilias. In: Oldham JM, Riba MB, eds. *Review of Psychiatry*. Vol 14. Washington, DC: American Psychiatric Press; 1995.
- Brame D, Jacobs J. *Different Loving: The World of Sexual Domination and Submission*. New York: Villard; 1996.
- \*Chasseguet-Smirgel J. *Creativity and Perversion*. New York: Norton; 1984.
- Dimen M. Perversion is us? Eight notes. In: *Sexuality, Intimacy, Power*. Hillsdale, NJ: The Analytic Press; 2003:257-291.
- Freud S. Three essays on the theory of sexuality. In: Strachey J, ed. *The Standard Edition of the Complete Works of Sigmund Freud*. Vol 7. London: Hogarth Press; 1905.
- Freud S. The economic problem of masochism. In: Strachey J, ed. *The Standard Edition of the Complete Works of Sigmund Freud*. Vol 19. London: Hogarth Press; 1961.
- Glover E: The relation of perversion formation to the development of reality sense. *Int J Psychoanal*. 1953;14:486-504.
- Hirigoyen MF. *Stalking the Soul: Emotional Abuse and the Erosion of Identity*. New York: Helen Marx Books 2000; 1998.
- Jacobson L: On the use of "sexual addiction": The case for "perversion." *Contemp Psychoanal*. 2003;39:107-113.
- \*Kernberg O. A theoretical frame for the study of sexual perversions. In: *Aggressive Personality Disorders and Perversions*. New Haven: Yale University Press; 1992.
- Kinsey A, Pomeroy W, Martin CE. *Sexual Behavior in the Human Male*. Philadelphia: WB Saunders; 1948.
- Krafft-Ebing R. *Psychopathia Sexualis*. Klaff SS, trans. New York: Stein and Day; 1965.
- \*Maletzky BM. The paraphilias: Research and treatment. In: Nathan PE, ed. *A Guide to Treatments that Work*. New York: Oxford University Press; 1998.
- McConaghy N: Methodological issues concerning evaluation of treatment for sexual offenders: Randomization, treatment dropouts, untreated controls, and within-treatment studies. *Sex Abuse J Res Treat*. 1998;11:183-193.
- \*McConaghy N: Unresolved issues in scientific sexology. *Arch Sex Behav*. 1999;28:285-318.
- McDougall J: Identifications, neoneeds, and neosexualities. *Int J Psychoanal*. 1986;67:19-31.
- McNulty RD, Adams HE, Dillon J. Sexual deviation: Paraphilias. In: Sutker PB, Adams HE, eds. *Comprehensive Handbook of Psychopathology*. New York: Kluwer Academic Publishers; 2001.
- Meltzer D. *Sexual States of Mind*. Perthshire, Scotland: Clunie Press; 1973.
- Nagel T: Sexual perversion. *J Philosophy*. 1969;66:5-17.
- Ostow M, Greenacre P: Perversions: General considerations concerning their genetic and dynamic background. In: *Emotional Background*. Vol 1. New York: International Universities Press; 1968.
- Ovesey L, Person ES: Transvestism: A disorder of the sense of self. *Int J Psychoanal Psychother*. 1976;5:219-236.
- Paul GCN: Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *J Consult Clin Psychol*. 1995;63:802-809.
- Person ES. *The Sexual Century*. New Haven: Yale University Press, 1999.
- Person ES, Terestman N, Myers WA, Goldberg EL, Salvadori C: Gender differences in sexual behaviors and fantasies in a college population. *J Sex Marital Ther*. 1989;15:187-198.
- Person ES. Sadomasochism: Interpersonal power corrupted by aggression. In: *Feeling Strong: The Achievement of Authentic Power*. New York: William Morrow; 2002:155-179.
- Richards AK: A fresh look at perversion. *JAPA*. 2003;51:1199-1218.
- Stoller RJ. *Perversion: The Erotic Form of Hatred*. New York: Pantheon Books; 1975.

## ▲ 18.3 Gender Identity Disorders

RICHARD GREEN, M.D., J.D.

### DEFINITIONS

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and the revised fourth edition of the DSM (DSM-IV-TR) define *gender identity disorders* as a group whose common feature is a strong, persistent preference for living as a person of the other sex. The affective component of gender identity disorders is

gender dysphoria, discontent with one's designated birth sex and a desire to have the body of the other sex, and to be regarded socially as a person of the other sex. *Gender identity disorder in adults* was referred to in early versions of the DSM as *transsexualism*.

In the current DSM-IV-TR, no distinction is made for the overriding diagnostic term *gender identity disorder* as a function of age. In children, it may be manifested as statements of wanting to be the other sex and as a broad range of sex-typed behaviors conventionally shown by children of the other sex.

In 1960, the author cowrote a paper describing behaviors in children that were consistent with the later described gender identity disorder of childhood. In 1974, the author published a text describing a few dozen boys with sexual identity conflict. Drawing on this clinical experience, the psychosexual disorders advisory committee of the DSM that was to become the third edition (DSM-III), on which the author served, introduced the diagnostic entity *gender identity disorder of childhood* in 1980.

Interest in gender identity disorders grew from several sources. Behaviors distinguished between male and female children are a focus of developmental psychologists studying conventional patterns of psychosexual differentiation. Work with sexually atypical adults, including transsexuals and homosexuals who recalled extensive cross-gender behavior in childhood, brought clinical interest to this area. Transsexuals became popularly known with the sex change of George Jorgensen into Christine Jorgensen in 1952. The 1966 book by Harry Benjamin, the pioneer who evaluated or treated many hundreds of patients, and the introduction of sex reassignment surgery at The Johns Hopkins Hospital in that same year were great strides in transsexualism's medical recognition and treatment.

### COMPARATIVE NOSOLOGY

Gender identity disorders first entered the American Psychiatric Association's nomenclature in DSM-III. They were included in the category of psychosexual disorders along with paraphilias and sexual dysfunctions. In the revised third edition of the DSM (DSM-III-R), gender identity disorders were placed in the section on disorders usually first evident in infancy, childhood, or adolescence. In DSM-IV, gender identity disorders were placed in a separate section called *sexual and gender identity disorders*.

**Number of Major Categories** In DSM-III, two specific categories of gender identity disorder were coded, each with its diagnostic criteria, that is *transsexualism* and *gender identity disorder of childhood*. The DSM-III-R had a third category, *gender identity disorder of adolescence or adulthood, nontranssexual type* to apply to persons with mild or fluctuating gender dysphoria.

DSM-IV reversed the trend to greater differentiation by reducing the number of major diagnostic categories to one, *gender identity disorders*. The objective of the change was to unify the diagnostic criteria for children, adolescents, and adults. However, the DSM-IV diagnostic criteria for nonadults did not fully parallel those for adults.

**Subtypes** DSM-III and DSM-III-R classified patients additionally by their sexual orientation. The heterosexual subtype of gender identity-disordered person was attracted to a person of the other genetic sex, the homosexual subtype was attracted to a person of the same genetic sex, and the asexual subtype was attracted to neither. DSM-IV continued the subtype classifications and added bisexuality but coded the individuals as sexually attracted to males, females, both, or neither, without calling the attraction homosexual or heterosexual.