

03 - 17.3 Paraphilic Disorders

17.3 Paraphilic Disorders

associated with severe mental disorders, such as schizophrenia and major mood disorders.

REFERENCES Basson R. Sexual desire and arousal disorders in women. *N Engl J Med*. 2006;354(15):1497. Brotto LA. "Efficacy of psychological interventions for sexual dysfunction: A systematic review and meta-analysis": Comment. *J Sex Med*. 2013;10:1904-1906. Fisher WA, Rosen RC, Mollen M, Brock G, Karlin G, Pommerville P, Goldstein I, Bangerter K, Bandel TJ, Derogatis LR, Sand M. Improving the sexual quality of life of couples affected by erectile dysfunction: A double-blind, randomized, placebocontrolled trial of vardenafil. *J Sex Med*. 2005;2(5):699. Frohman EM. Sexual dysfunction in neurological disease. *Clin Neuropharmacol*. 2002;25:126. Fugl-Meyer KS, Oberg K, Lundberg PO, Lewin B, Fugl-Meyer A. On orgasm, sexual techniques, and erotic perceptions in 18- to 74-year-old Swedish women. *J Sex Med*. 2006;3:56-68. Gopalakrishnan R, Jacob KS, Kuruvilla A, Vasantharaj B, John JK. Sildenafil in the treatment of antipsychotic-induced erectile dysfunction: A randomized, double-blind, placebo-controlled, flexible-dose, two-way crossover trial. *Am J Psychiatry*. 2006;163:494-499. Gross G, Blundo R. Viagra: Medical technology constructing aging masculinity. *Journal of Sociology & Social Welfare*. 2005;32:85-97. Oliviera C. and Nobre PJ. The role of trait-affect, depression, and anxiety in women with sexual dysfunction: A pilot study. *J Sex Marital Ther*. 2013;39:436-452 Pauls RN, Kleeman SD, Karram MM. Female sexual dysfunction: Principles of diagnosis and therapy. *Obstet Gynecol Surv*. 2005;60(3):196-205. Reichenpfader U, Gartlehner G, Morgan LC, Greenblatt A, Nussbaumer B, Hansen RA, Van Noord N, Lux L, Gaynes BN. Sexual dysfunction associated with second-generation antidepressants in patients with major depressive disorder: results from a systematic review with network meta-analysis. *Drug Saf*. 2014;37(1):19-31. Rhoden EL, Morgentaler A. Risks of testosterone-replacement therapy and recommendations deficiency. *N Engl J Med*. 2004;350:482. Rosen R, Shabsigh R, Berber M, Assalian P, Menza M, Rodriguez-Vela L, Porto R, Bangerter K, Seger M, Montorsi F, The Vardenafil Study Site Investigators. Efficacy and tolerability of vardenafil in men with mild depression and erectile dysfunction: The depression-related improvement with vardenafil for erectile response study. *Am J Psychiatry*. 2006;163:79-87. Sadock VA. Normal human sexuality and sexual dysfunction. In: Sadock BJ, Sadock VA, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 9th ed. Vol. 1. Philadelphia: Lippincott Williams & Wilkins; 2009:1902. Sadock VA. Group psychotherapy of psychosexual dysfunctions. In: Kaplan HI, Sadock BJ, eds. *Comprehensive Group Psychotherapy*. Baltimore: Williams & Wilkins;1983:286. Serretti A, Chiesa A. Sexual dysfunction and antidepressants: Identification, epidemiology, and treatment. *Directions in*

Psychiatry. 2013;33:1-11 Woodward TL, Nowak NT, Balon R, Tancer M, Diamond MP. Brain activation patterns in women with acquired hypoactive desire disorder and women with normal function: A cross-sectional pilot study. Fertil Steril. 2013;100:1068-1076. 17.3 Paraphilic Disorders

Paraphilias or perversions are sexual stimuli or acts that are deviations from normal sexual behaviors, but are necessary for some persons to experience arousal and orgasm. According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), the term paraphilic disorder is reserved for those cases in which a sexually deviant fantasy or impulse has been expressed behaviorally. Individuals with paraphilic interests can experience sexual pleasure, but they are inhibited from responding to stimuli that are normally considered erotic. The paraphiliac person's sexuality is mainly restricted to specific deviant stimuli or acts. Persons that occasionally experiment with paraphilic behavior (e.g., infrequent episode of bondage or dressing in costumes), but are capable of responding to more typical erotic stimuli, are not seen as having paraphilic disorders. Paraphilic disorders can range from nearly normal behavior to behavior that is destructive or hurtful only to a person's self or to a person's self and partner, and finally to behavior that is deemed destructive or threatening to the community at large. DSM-5 lists pedophilia, frotteurism, voyeurism, exhibitionism, sexual sadism, sexual masochism, fetishism, and transvestism with explicit diagnostic criteria because of their threat to others and/or because they are relatively common paraphilias. There are many other paraphilias that may be diagnosed. A paraphilia is clinically significant if the person has acted on these fantasies or if these fantasies cause marked distress or interpersonal difficulty or job-related difficulty. However, when the fantasy has not been acted upon, the term paraphilic disorder should not be applied. In the paraphilias listed earlier, with the exception of pedophilia, the specifiers, "in a controlled environment" (where the fantasy cannot easily be acted upon due to circumstances, such as being in an institution) and "in full remission" (when the patient has not acted on the fantasies for 5 years and there has been no impairment in interpersonal or occupational functioning in an uncontrolled environment for 5 years) are added. A special fantasy with its unconscious and conscious components is the pathognomonic element of the paraphilia, with sexual arousal and orgasm being associated phenomena that reinforce the fantasy or impulse. The influence of these fantasies and their behavioral manifestations often extend beyond the sexual sphere to pervade people's lives. The major functions of human sexual behavior are to assist in bonding, to create mutual pleasure in cooperation with a partner, to express and enhance love between two persons, and to procreate. Paraphilic disorders entail divergent behaviors in that those acts involve aggression, victimization, and extreme one-sidedness. The behaviors exclude or harm others and disrupt the potential for bonding between persons. Moreover, paraphilic sexual scripts often serve other vital psychic functions. They may assuage anxiety, bind aggression, or stabilize identity.

EPIDEMIOLOGY Paraphilias are practiced by only a small percentage of the population, but the insistent, repetitive nature of the disorders results in a high frequency of such acts. Thus, a large proportion of the population has been victimized by persons with paraphilic disorders.

It has been suggested that the prevalence of paraphilias is significantly higher than the number of cases diagnosed in general clinical facilities, based on the large commercial market in paraphilic pornography and paraphernalia. Is not known how many of the consumers of this material act on paraphilic fantasies or cannot respond to typical erotic stimuli. Among legally identified cases of paraphilic disorders, pedophilia is most common. Of all children, 10 to 20 percent have been molested by age 18. Because a child is the object, the act is taken more seriously, and greater

effort is spent tracking down the culprit than in other paraphilic disorders. Persons with exhibitionism who publicly display themselves to young children are also commonly apprehended. Those with voyeurism may be apprehended, but their risk is not great. Of adult females, 20 percent have been the targets of persons with exhibitionism and voyeurism. Sexual masochism and sexual sadism are underrepresented in any prevalence estimates. Sexual sadism usually comes to attention only in sensational cases of rape, brutality, and lust murder. The excretory paraphilic disorders are scarcely reported, because activity usually takes place between consenting adults or between prostitute and client. Persons with fetishism rarely become entangled in the legal system. Those with transvestism may be arrested occasionally for disturbing the peace or on other misdemeanor charges if they are obviously men dressed in women's clothes, but arrest is more common among those with gender identity disorders. Zoophilia as a true paraphilic disorder is rare (Table 17.3-1). Table 17.3-1 Frequency of Paraphilic Acts Committed by Patients with Paraphilia Seeking Outpatient Treatment As usually defined, the paraphilias seem to be largely male conditions. Fetishism almost always occurs in men. More than 50 percent of all paraphilias have their onset before age 18. Patients with paraphilia frequently have three to five paraphilias, either concurrently or at different times in their lives. This pattern of occurrence is especially the case with exhibitionism, fetishism, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and zoophilia (see Table 17.3-1). The occurrence of paraphilic behavior peaks between ages 15 and 25 and gradually declines. DSM-5 suggests the

paraphilia designation be reserved for those ages 18 and older to avoid pathologizing normal sexual curiosity and occasional experimentation in adolescence. In men older than 50, criminal paraphilic acts are rare. Those that occur are practiced in isolation or with a cooperative partner.

ETIOLOGY Psychosocial Factors In the classic psychoanalytic model, persons with a paraphilia have failed to complete the normal developmental process toward sexual adjustment, but the model has been modified by new psychoanalytic approaches. What distinguishes one paraphilia from another is the method chosen by a person (usually male) to cope with the anxiety caused by the threat of castration by the father and separation from the mother. However bizarre its manifestation, the resulting behavior provides an outlet for the sexual and aggressive drives that would otherwise have been channeled into normal sexual behavior. Failure to resolve the oedipal crisis by identifying with the father-aggressor (for boys) or mother-aggressor (for girls) results either in improper identification with the opposite-sex parent or in an improper choice of object for libido cathexis. Classic psychoanalytic theory holds that transsexualism and transvestic fetishism are disorders because each involves identification with the opposite-sex parent instead of the same-sex parent; for instance, a man dressing in women's clothes is believed to identify with his mother. Exhibitionism and voyeurism may be attempts to calm anxiety about castration because the reaction of the victim or the arousal of the voyeur reassures the paraphilic person that the penis is intact. Fetishism is an attempt to avoid anxiety by displacing libidinal impulses to inappropriate objects. A person with a shoe fetish unconsciously denies that women have lost their penises through castration by attaching libido to a phallic object, the shoe, which symbolizes the female penis. Persons with pedophilia and sexual sadism have a need to dominate and control their victims to compensate for their feelings of powerlessness during the oedipal crisis. Some theorists believe that choosing a child as a love object is a narcissistic act. Persons with sexual masochism overcome their fear of injury and their sense of powerlessness by showing that they are impervious to harm. Another theory proposes that the masochist directs the aggression inherent in all paraphilias toward herself or himself. Although recent developments in psychoanalysis place more

emphasis on treating defense mechanisms than on oedipal traumas, psychoanalytic therapy for patients with a paraphilia remains consistent with Sigmund Freud's theory. Other theories attribute the development of a paraphilia to early experiences that condition or socialize children into committing a paraphilic act. The first shared sexual experience can be important in that regard. Molestation as a child can predispose a person to accept continued abuse as an adult or, conversely, to become an abuser of others. Also, early experiences of abuse that are not specifically sexual, such as spanking, enemas, or verbal humiliation, can be sexualized by a child and can form the

basis for a paraphilia. Such experiences can result in the development of an eroticized child. A 34-year-old man presented for treatment with a chief complaint of erectile disorder. He was frequently unable to obtain an erection sufficient for coitus with his wife. The problem disappeared whenever she was willing to act out his bondage fantasy and tie him up with ropes, a scenario he intensely desired. He explained that he felt free to be sexual when he was tied up because it reassured him that he could move vigorously and not hurt the woman. In addition, he gave a history of being tied up "in fun" when he was a child by a babysitter who would then tickle him until he begged her to stop. The onset of paraphilic acts can result from persons' modeling their behavior on the behavior of others who have carried out paraphilic acts, mimicking sexual behavior depicted in the media, or recalling emotionally laden events from the past, such as their own molestation. Learning theory indicates that because the fantasizing of paraphilic interests begins at an early age and because personal fantasies and thoughts are not shared with others (who could block or discourage them), the use and misuse of paraphilic fantasies and urges continue uninhibited until late in life. Only then do persons begin to realize that such paraphilic interests and urges are inconsistent with societal norms. By that time, however, the repetitive use of such fantasies has become ingrained, and the sexual thoughts and behaviors have become associated with, or conditioned to, paraphilic fantasies.

Biological Factors Several studies have identified abnormal organic findings in persons with paraphilias. None has used random samples of such persons; instead, they have extensively investigated patients with paraphilia who were referred to large medical centers. Among these patients, those with positive organic findings included 74 percent with abnormal hormone levels, 27 percent with hard or soft neurological signs, 24 percent with chromosomal abnormalities, 9 percent with seizures, 9 percent with dyslexia, 4 percent with abnormal electroencephalography (EEG) studies, 4 percent with major mental disorders, and 4 percent with mental handicaps. The question is whether these abnormalities are causally related to paraphilic interests or are incidental findings that bear no relevance to the development of paraphilia. Psychophysiological tests have been developed to measure penile volumetric size in response to paraphilic and nonparaphilic stimuli. The procedures may be of use in diagnosis and treatment, but are of questionable diagnostic validity because some men are able to suppress their erectile responses.

DIAGNOSIS AND CLINICAL FEATURES In DSM-5, the criteria for paraphilic disorder requires the patient to have experienced intense and recurrent arousal from their deviant fantasy for at least 6 months and to have acted on the paraphilic impulse. The presence of a paraphilic fantasy, however,

may still distress a patient even if there has been no behavioral elaboration. The fantasy distressing the patient contains unusual sexual material that is relatively fixed and shows only minor variations. Arousal and orgasm depend on the mental elaboration, if not the behavioral playing out of the fantasy. Sexual activity is ritualized or stereotyped and makes use of degraded, reduced, or dehumanized objects.

Exhibitionism Exhibitionism is the recurrent urge to expose the

genitals to a stranger or to an unsuspecting person. Sexual excitement occurs in anticipation of the exposure, and orgasm is brought about by masturbation during or after the event. In almost 100 percent of cases, those with exhibitionism are men exposing themselves to women. The dynamic of men with exhibitionism is to assert their masculinity by showing their penises and by watching the victims' reactions—fright, surprise, and disgust. In this paraphilic disorder, men unconsciously feel castrated and impotent. Wives of men with exhibitionism often substitute for the mothers to whom the men were excessively attached during childhood, or conversely, by whom they were rejected. In other related paraphilias, the central themes involve derivatives of looking or showing. A substance-abusing professional was finally able to attain sobriety at age 33 years. With this accomplishment, he met a woman and got married, began to work steadily for the first time in his life, and was able to impregnate his new wife. His preferred sexual activity had been masturbation in semi-public places. The patient had a strong sense that his mother had always thought him to be inadequate, did not like to spend time with him, and constantly made negative comparisons between him and his "allboy" younger brother. He recalled several times when his father had tried to explain his mother's antipathy: "It is just one of those things son: your mother does not seem to like you." Without substance abuse, he gave up his exhibitionism, but he quickly developed sexual incapacity with his wife and became "addicted" to phone sex. (Courtesy of Stephen B. Levine, M.D.) Specifiers added to exhibitionistic disorder by DSM-5 differentiate arousal from exposing genitals to prepubertal children, to physically mature individuals, or to both prepubertal children and physically mature individuals. Fetishism In fetishism the sexual focus is on objects (e.g., shoes, gloves, pantyhose, and stockings) that are intimately associated with the human body, or on nongenital body parts. The latter focus is sometimes called partialism and is discussed later. DSM-5 applies the diagnosis fetishistic disorder to partialism and attaches the following specifiers to fetishistic disorder: body part(s); non-living parts; other. The particular fetish used is linked to someone closely involved with a patient during childhood and has a quality

associated with this loved, needed, or even traumatizing person. Usually, the disorder begins by adolescence, although the fetish may have been established in childhood. Once established, the disorder tends to be chronic. Sexual activity may be directed toward the fetish itself (e.g., masturbation with or into a shoe), or the fetish may be incorporated into sexual intercourse (e.g., the demand that high-heeled shoes be worn). The disorder is almost exclusively found in men. According to Freud, the fetish serves as a symbol of the phallus to persons with unconscious castration fears. Learning theorists believe that the object was associated with sexual stimulation at an early age. A 50-year-old man entered treatment with a chief complaint of erectile disorder experienced primarily with his wife. He was suffering from a moderate depression that related to both his marital issues and business problems. He had no erectile problems with women he picked up in bars or knew and arranged to meet in bars. Bars were his chosen venue in part because smoking had been prohibited in other public areas in his city and a woman's act of smoking a cigarette was necessary to his sexual arousal. His family history included an alcoholic mother and an emotionally abusive father who was a chain smoker. On family car trips the father would smoke, with all the car windows up. If the patient complained of feeling nauseous the father would tell him to "shut up." He recalled being very attracted to a Sunday school teacher who smoked when he was 6 years old. He first smoked when he was 13, sneaking and hiding behind his house. His first cigarette was one he stole from a pack on his mother's night table. Frotteurism Frotteurism is usually characterized by a man's rubbing his penis against the buttocks or other body parts of a fully clothed woman to achieve orgasm. At other times, he may use his hands to rub an

unsuspecting victim. The acts usually occur in crowded places, particularly in subways and buses. Those with frotteurism are extremely passive and isolated, and frottage is often their only source of sexual gratification. The expression of aggression in this paraphilia is readily apparent. Pedophilia involves recurrent intense sexual urges toward, or arousal by, children 13 years of age or younger, over a period of at least 6 months. Persons with pedophilia are at least 16 years of age and at least 5 years older than the victims. When a perpetrator is a late adolescent involved in an ongoing sexual relationship with a 12- or 13-year-old, the diagnosis is not warranted. Most child molestations involve genital fondling or oral sex. Vaginal or anal penetration of children occurs infrequently, except in cases of incest. Although most

child victims coming to public attention are girls, this finding appears to be a product of the referral process. Offenders report that when they touch a child, most (60 percent) of the victims are boys. This figure is in sharp contrast to the figure for nontouching victimization of children, such as window peeping and exhibitionism; 99 percent of all such cases are perpetrated against girls. DSM-5 adds the following specifiers to a diagnosis of pedophilic disorder: sexually attracted to males; sexually attracted to females; or sexually attracted to both. Of persons with pedophilia, 95 percent are heterosexual, and 50 percent have consumed alcohol to excess at the time of the incident. In addition to their pedophilia, a significant number of the perpetrators are concomitantly or have previously been involved in exhibitionism, voyeurism, or rape. Incest is related to pedophilia by the frequent selection of an immature child as a sex object, the subtle or overt element of coercion, and occasionally the preferential nature of the adult-child liaison. A 62-year-old married janitor had worked as a fourth-grade school teacher for 26 years before he transferred school districts, and finally several years later mysteriously lost his second job. He was referred for help after his family discovered that he had repeatedly fondled the genitals of his 4- and 6-year-old granddaughters. A father of five who had not had sex with his wife for 30 years after strenuously objecting to her cigarette smoking, he was generous, helpful, and cooperative with his children and grandchildren. Intellectually slow, he preferred comic books and had a charming manner of playing with young children "like he was one himself." By his estimate he had touched the buttocks and genitals of at least 300 girl students, thinking only of how they did not know what he was doing because he was being affectionate and they were too young to realize what was happening. He loved the anticipation and excitement of this behavior. His teaching career ended when parents complained to a principal. The principal discovered that the new teacher had been transferred, not fired from his longstanding teaching job for the same reason. The patient had tried to touch his 12-year-old daughter who angrily warned him to stay away from her, but he had also managed to touch her friends and his best friend's daughters as they neared puberty. (Courtesy of Stephen B. Levine, M.D.)

Sexual Masochism Masochism takes its name from the activities of Leopold von Sacher-Masoch, a 19th century Austrian novelist whose characters derived sexual pleasure from being abused and dominated by women. According to the DSM-5, persons with sexual masochism have a recurrent preoccupation with sexual urges and fantasies involving the act of being humiliated, beaten, bound, or otherwise made to suffer. A specifier added to this disorder diagnosis is: with asphyxiophilia; also called autoerotic asphyxiation, this is the practice of achieving or heightening sexual arousal with restriction of breathing. Sexual

masochistic practices are more common among men than among women. Freud believed masochism resulted from destructive fantasies turned against the self. In some cases, persons can allow themselves to experience sexual feelings only when punishment for the feelings follows.

Persons with sexual masochism may have had childhood experiences that convinced them that pain is a prerequisite for sexual pleasure. About 30 percent of those with sexual masochism also have sadistic fantasies. Moral masochism involves a need to suffer, but is not accompanied by sexual fantasies. A 27-year-old woman presented for an interview with the director of a course to which she had applied and which she was eager to take. She appeared at the interview in the company of a man whom she introduced to the director, saying, "This is my lover." When asked about this unusual behavior during the interview, the applicant stated that her companion had ordered her to bring him and make that introduction. She further explained that she was part of a group that utilized sadomasochistic techniques in their sexual play. Sexual Sadism DSM-5 defines sexual sadism as the recurrent and intense sexual arousal from the physical and psychological suffering of another person. A person must have experienced these feelings for at least 6 months, and must have acted on sadistic fantasies to receive a diagnosis of sexual sadism disorder. Persons who deny behavioral elaboration of their paraphilic fantasies and who say they suffer no distress, or interpersonal or social difficulties, as a consequence of their paraphilias are designated as having an ascertained sexual sadism interest. The onset of the disorder is usually before the age of 18 years, and most persons with sexual sadism are male. According to psychoanalytic theory, sadism is a defense against fears of castration; persons with sexual sadism do to others what they fear will happen to them and derive pleasure from expressing their aggressive instincts. The disorder was named after the Marquis de Sade, an 18th century French author and military officer who was repeatedly imprisoned for his violent sexual acts against women. Sexual sadism is related to rape, although rape is more aptly considered an expression of power. Some sadistic rapists, however, kill their victims after having sex (so-called lust murders). In many cases, these persons have underlying schizophrenia. John Money believes that lust murderers suffer from dissociative disorder and perhaps have a history of head trauma. He lists five contributory causes of sexual sadism: hereditary predisposition, hormonal malfunctioning, pathological relationships, a history of sexual abuse, and the presence of other mental disorders. Voyeurism Voyeurism, also known as scopophilia, is the recurrent preoccupation with fantasies and

acts that involve observing unsuspecting persons who are naked or engaged in grooming or sexual activity. Masturbation to orgasm usually accompanies or follows the event. The first voyeuristic act usually occurs during childhood, and the paraphilia is most common in men. When persons with voyeurism are apprehended, the charge is usually loitering. Transvestism Transvestism, formerly called transvestic fetishism, is described as fantasies and sexual urges to dress in opposite gender clothing as a means of arousal and as an adjunct to masturbation or coitus. The diagnosis is given when the transvestic fantasies have been acted upon for at least 6 months. DSM-5 requires specifiers with a diagnosis of transvestic disorder: with fetishism is added if the patient is aroused by fabrics, materials, or garments; with autogynephilia is added if the patient is sexually aroused by thoughts or images of himself as a female. Transvestism typically begins in childhood or early adolescence. As years pass, some men with transvestism want to dress and live permanently as women. Very rarely, women want to dress and live as men. These persons are classified in DSM-5 as persons with transvestic disorder and gender dysphoria. Usually, a person wears more than one article of opposite sex clothing; frequently, an entire wardrobe is involved. When a man with transvestism is cross-dressed, the appearance of femininity may be striking, although not usually to the degree found in transsexualism. When not dressed in women's clothes, men with transvestism may be hypermasculine in appearance and occupation. Cross-dressing can be graded from solitary, depressed, guilt-ridden dressing to ego-syntonic, social membership in a transvestite

subculture. The overt clinical syndrome of transvestism may begin in latency, but is more often seen around pubescence or in adolescence. Frank dressing in opposite sex clothing usually does not begin until mobility and relative independence from parents are well established. Other Specified Paraphilic Disorder This classification includes various paraphilias that cause personal distress and that have been acted upon for 6 months that do not meet the criteria for any of the aforementioned categories. The same definition applies to Unspecified Paraphilic Disorder, with the difference that the clinician does not wish to specify the particular paraphilia for reasons that may include not having sufficient information. TELEPHONE AND COMPUTER SCATOLOGIA. Telephone scatologia is characterized by obscene phone calling and involves an unsuspecting partner. Tension and arousal begin in anticipation of phoning; the recipient of the call listens while the telephoner (usually male) verbally exposes his preoccupations or induces her to talk about her sexual activity. The conversation is accompanied by masturbation, which is often completed after the contact is interrupted. Persons also use interactive computer networks, sometimes compulsively, to send obscene messages by electronic mail

and to transmit sexually explicit messages and video images. Because of the anonymity of the users in chat rooms who use aliases, on-line or computer sex (cybersex) allows some persons to play the role of the opposite sex ("genderbending"), which represents an alternative method of expressing transvestic or transsexual fantasies. A danger of on-line cybersex is that pedophiles often make contact with children or adolescents who are lured into meeting them and are then molested. Many on-line contacts develop into off-line liaisons. Although some persons report that the off-line encounters develop into meaningful relationships, most such meetings are filled with disappointment and disillusionment, as the fantasized person fails to meet unconscious expectations of the ideal partner. In other situations, when adults meet, rape or even homicide may occur. NECROPHILIA. Necrophilia is an obsession with obtaining sexual gratification from cadavers. Most persons with this disorder find corpses in morgues, but some have been known to rob graves or even to murder to satisfy their sexual urges. In the few cases studied, those with necrophilia believed that they were inflicting the greatest conceivable humiliation on their lifeless victims. According to Richard von Krafft-Ebing, the diagnosis of psychosis is, under all circumstances, justified. PARTIALISM. Persons with the disorder of partialism concentrate their sexual activity on one part of the body to the exclusion of all others. Mouth-genital contact—such as cunnilingus (oral contact with a woman's external genitals), fellatio (oral contact with the penis), and anilingus (oral contact with the anus)—is normally associated with foreplay; Freud recognized the mucosal surfaces of the body as erotogenic and capable of producing pleasurable sensation. But when a person uses these activities as the sole source of sexual gratification and cannot have or refuses to have coitus, a paraphilia exists. It is also known as oralism. ZOOPHILIA. In zoophilia, animals—which may be trained to participate—are preferentially incorporated into arousal fantasies or sexual activities, including intercourse, masturbation, and oral-genital contact. Zoophilia as an organized paraphilia is rare. For many persons, animals are the major source of relatedness, so it is not surprising that a broad variety of domestic animals are used sensually or sexually. Sexual relations with animals may occasionally be an outgrowth of availability or convenience, especially in parts of the world where rigid convention precludes premarital sexuality and in situations of enforced isolation. Because masturbation is also available in such situations, however, a predilection for animal contact is probably present in opportunistic zoophilia. COPROPHILIA AND KLISMAPHILIA. Coprophilia is sexual pleasure associated with the desire to defecate on a partner, to be defecated on, or to eat feces (coprophagia). A variant is the

compulsive utterance of obscene words (coprolalia). These paraphilias are associated with fixation at the anal stage of psychosexual development. Similarly, klismaphilia, the use of enemas as part of sexual stimulation, is related to anal fixation. UROPHILIA. Urophilia, a form of urethral eroticism, is interest in sexual pleasure associated with the desire to urinate on a partner or to be urinated on. In both men and women, the disorder may be associated with masturbatory techniques involving the

insertion of foreign objects into the urethra for sexual stimulation. MASTURBATION. Masturbation is a normal activity that is common in all stages of life from infancy to old age, but this viewpoint was not always accepted. Freud believed that neurasthenia was caused by excessive masturbation. In the early 1900s, masturbatory insanity was a common diagnosis in hospitals for the criminally insane in the United States. Masturbation can be defined as a person's achieving sexual pleasure—which usually results in orgasm—by himself or herself (autoeroticism). Alfred Kinsey found it to be more prevalent in males than in females, but this difference may no longer exist. The frequency of masturbation varies from three to four times a week in adolescence to one to two times a week in adulthood. It is common among married persons; Kinsey reported that it occurred on the average of once a month among married couples. The techniques of masturbation vary in both sexes and among persons. The most common technique is direct stimulation of the clitoris or penis with the hand or the fingers. Indirect stimulation can also be used, such as rubbing against a pillow or squeezing the thighs. Kinsey found that 2 percent of women are capable of achieving orgasm through fantasy alone. Men and women have been known to insert objects in the urethra to achieve orgasm. The hand vibrator is now used as a masturbatory device by both sexes. Masturbation is abnormal when it is the only type of sexual activity performed in adulthood if a partner is or might be available, when its frequency indicates a compulsion or sexual dysfunction, or when it is consistently preferred to sex with a partner (Fig. 17.3-1).

FIGURE 17.3-1 A man who masturbated compulsively with a large electrically powered vibrator by inserting the head of the instrument into his anus was unable to retrieve it when it was inserted too far into the anal canal. (Courtesy of Stephen Baker, M.D.) HYPOXYPHILIA. Hypoxyphilia is the desire to achieve an altered state of consciousness secondary to hypoxia while experiencing orgasm. Persons may use a drug (e.g., a volatile nitrite or nitrous oxide) to produce hypoxia. Autoerotic asphyxiation is also associated with hypoxic states, but it should be classified as a form of sexual masochism. DIFFERENTIAL DIAGNOSIS Clinicians must differentiate a paraphilia from an experimental act that is not recurrent or compulsive and that is done for its novelty. Paraphilic activity most likely begins during adolescence. Some paraphilias (especially the bizarre types) are associated with other mental disorders, such as schizophrenia. Brain diseases can also release perverse impulses. COURSE AND PROGNOSIS The difficulty in controlling or curing paraphilic disorders rests in the fact that it is hard for people to give up sexual pleasure with no assurance that new routes to sexual gratification will be secured. A poor prognosis for paraphilic disorder is associated with an early age of onset, a high frequency of acts, no guilt or shame about the act, and substance abuse. The course and the prognosis are better when patients have a history of coitus in addition to the paraphilia, and when they are self-referred rather than referred by a legal agency. TREATMENT Five types of psychiatric interventions are used to treat persons with paraphilic disorder and paraphilic interests: external control, reduction of sexual drives, treatment of comorbid conditions (e.g., depression or anxiety), cognitive-behavioral therapy, and dynamic psychotherapy. Prison is an external control mechanism for sexual crimes that usually does not

contain a treatment element. When victimization occurs in a family or work setting, the external control comes from informing supervisors, peers, or other adult family members of the problem and advising them about eliminating opportunities for the perpetrator to act on urges. Drug therapy, including antipsychotic or antidepressant medication, is indicated for the treatment of schizophrenia or depressive disorders if the paraphilia is associated with these disorders. Antiandrogens, such as cyproterone acetate in Europe and medroxyprogesterone acetate (Depo-Provera) in the United States, may reduce the drive to behave sexually by decreasing serum testosterone levels to subnormal concentrations.

Serotonergic agents, such as fluoxetine (Prozac), have been used with limited success in some patients with paraphilia. Cognitive-behavioral therapy is used to disrupt learned paraphilic patterns and modify behavior to make it socially acceptable. The interventions include social skills training, sex education, cognitive restructuring (confronting and destroying the rationalizations used to support victimization of others), and development of victim empathy. Imaginal desensitization, relaxation technique, and learning what triggers the paraphilic impulse so that such stimuli can be avoided are also taught. In modified aversive behavior rehearsal, perpetrators are videotaped acting out their paraphilia with a mannequin. Then the patient with paraphilic disorder is confronted by a therapist and a group of other offenders who ask questions about feelings, thoughts, motives associated with the act and repeatedly try to correct cognitive distortions and point out lack of victim empathy to the patient. Insight-oriented psychotherapy is a long-standing treatment approach. Patients have the opportunity to understand their dynamics and the events that caused the paraphilia to develop. In particular, they become aware of the daily events that cause them to act on their impulses (e.g., a real or fantasized rejection). Treatment helps them deal more effectively with life stresses and enhances their capacity to relate to a life partner. In addition, psychotherapy allows patients to regain self-esteem, which in turn allows them to approach a partner in a more normal sexual manner. Sex therapy is an appropriate adjunct to the treatment of patients with specific sexual dysfunctions when they attempt nondeviant sexual activities. Good prognostic indicators include the presence of only one paraphilia, normal intelligence, the absence of substance abuse, the absence of nonsexual antisocial personality traits, and the presence of a successful adult attachment. Paraphilic disorders, however, remain significant treatment challenges even under these circumstances.

REFERENCES

Carnes PJ, Murray R, Charpentier L. Addiction interaction disorder. In: Combs RH, ed. *Handbook of Addictive Disorders: A Practical Guide to Diagnosis and Treatment*. Hoboken, NJ: John Wiley & Sons; 2004:31.

Ceccarelli P. Perversion on the other side of the couch. *International Forum of Psychoanalysis*. 2005;14:176-182.

Charnigo R, Noar SM, Garnett C, Crosby R, Palmgreen P, Zimmerman RS. Sensation seeking and impulsivity. *J Sex Res*. 2013;50:480-488.

Chirban JT. Integrative strategies for treating internet sexuality: A case study of paraphilias. *Clinical Case Studies*. 2006;5:126-141.

Dimen M. Perversion is us? Eight notes. In: *Sexuality, Intimacy, Power*. Hillsdale, NJ: The Analytic Press; 2003:257-291.

Egan V, Parmar R. Dirty habits? Online pornography use, personality, obsessionality, and compulsivity. *J Sex Marital Ther*. 2013;39:394-409.

Jacobson L. On the use of "sexual addiction": The case for "perversion." *Contemp Psychoanal*. 2003;39:107-113.

Kafka MP. The monoamine hypothesis for the pathophysiology of paraphilic disorders: An update. *Ann N Y Acad Sci*. 2003;989:86.

Kafka MP, Hennen J. Hypersexual desire in males: Are males with paraphilias different from males with paraphilia-related disorders? *Sex Abuse*. 2003;15:307.

Nestler EJ, Malenka RC. The addicted brain. *Sci Am*. 2004;290:78.

Person ES. Paraphilias. In: Sadock BJ, Sadock VA, eds. *Kaplan & Sadock's*

Comprehensive Textbook of Psychiatry. 9th ed. Vol. 1. Philadelphia: Lippincott Williams & Wilkins; 2009:1965. Raymond NC, Coleman E, Miner MH. Psychiatric comorbidity and compulsive/impulsive traits in compulsive sexual behavior. Compr Psychiatry. 2003;44:370. Richards AK. A fresh look at perversion. J Am Psychoanal Assoc. 2003;51:1199–1218. Sadock VA. Sexual Addiction in Substance Abuse, A Comprehensive Textbook. Ruiz P, Strain E, eds. Lippincott William & Wilkins; 2011:393. Simkovic M, Stulhofer A, Bozic J. Revisiting the association between pornography use and risky sexual behaviors: The role of early exposure to pornography and sexual sensation seeking. J Sex Res. 2013;50:633–641. Yakeley J, Wood H. Paraphilias and paraphilic disorders: diagnosis, assessment and management. Adv Psychiatr Treat . 2014;20(3):202–213.

Revision #1

Created 2026-01-04 19:51:07 UTC by Omar Ayman

Updated 2026-01-04 19:51:07 UTC by Omar Ayman