Paraphilias: Clinical and Forensic Considerations

April 15, 2007 | Forensic Psychiatry [1], Bipolar Disorder [2], Schizophrenia [3], Comorbidity In Psychiatry [4], Sadism [5], Antisocial Personality Disorder [6], Gender Issues [7], Masochism [8], Mood Disorders [9], Addiction [10] By H. Martin Malin, PhD [11] and Fabian M. Saleh, MD [12]

Paraphilias are defined by DSM-IV-TR as sexual disorders characterized by "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 6 months" (Criterion A), which "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Criterion B). DSM-IV-TR describes 8 specific disorders of this type (exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, voyeurism, and transvestic fetishism) along with a ninth residual category, paraphilia not otherwise specified (NOS).

It has been estimated that some 50 paraphilias have been identified and described in the literature. Many, like klismaphilia (erotic arousal to enemas) are not illegal and therefore do not often come to the attention of therapists even though they may fulfill DSM Criteria A and B requirements. Thus, the category paraphilia NOS comprises most of the paraphilias described in the literature, although not necessarily the largest number of individuals with paraphilias. The sheer variety of erotic material available on the Internet and other adult entertainment venues lends credence to this assumption. A content analysis of these materials would likely provide a reasonably accurate indication of the prevalence of these paraphilias—at least the legal ones.

With the exception of those who are in legal trouble, most, but not all, persons with paraphilia probably do not seek treatment. Indeed, it has been argued that the impact of the mandatory reporting laws enacted for certain sexual crimes has further decreased the number of individuals seeking voluntary treatment.1,2

To the layperson, paraphilias are commonly regarded as "kinky sex." Both canon law and common law proscribed most paraphilic thoughts and behaviors long before they came to be regarded by medical science as indicators of possible mental illness. By the time of Richard von Krafft-Ebing at the turn of the 20th century, medicine's interest in "abnormal" sexual behavior had come into full flower, and Krafft-Ebing made liberal use of such legal terminology as "perversion" and "deviancy" in his case studies.

An attempt to move away from such legally pejorative terminology eventually succeeded in the adoption of the term paraphilia, from the Greek prefix para meaning "around" or "beside" (within the context, implying "altered" or "missing the mark") and philia, 1 of 3 ancient Greek words for love. Benjamin Karpman gets credit for introducing English speakers to the term paraphilia.3

In the end, however, paraphilia and paraphile may be destined to join the pejorative ranks of such descriptors as perversion or pervert. Many well-educated individuals confuse paraphile with pedophile. Perhaps worse, because of a lack of understanding or disregard for the phenomenology of the paraphilias, physicians, lawyers, journalists, and other professionals readily conflate the medical term pedophile with the term child molester. It is a small jump from that error to conceptualizing all persons with paraphilia as sex offenders.

DSM nosology, and to some extent, therefore, psychiatry's understanding of the paraphilias, has not been consistent. The term paraphilia first appeared in DSM-III. The enumerated paraphilias included zoophilia but not frotteurism and specified a category for atypical paraphilias. DSM-III-R dropped
zoophilia but added frotteurism and renamed the residual atypical class paraphilias NOS. The 1987
categories remain, with minor semantic changes, the same in the DSM-IV and DSM-IV-TR editions.
In addition, DSM has not always classified paraphilias as sexual disorders. Beginning with the first
DSM published in 1952, sexual deviations, as the paraphilias were then called, were conceptualized
as a subclass of sociopathic personality disturbances—a category that included most diagnoses
"formerly classed as psychopathic personality with pathologic sexuality," adding that the diagnosis
should specify the "type of the pathologic behavior, such as homosexuality, transvestism, pedophilia,
fetishism, and sexual sadism (including rape, assault, mutilation)." The personality disorders of the first DSM were distinguished from psychophysiological autonomic
and visceral disorders that were believed to be more physiologically based than certain other mental
disorders. As such, they were differentiated from sexual dysfunctions and gender disturbances. The
subcategory, psychophysiological genitourinary reaction appears to have been the rough equivalent of
the sexual dysfunctions subcategory of the sexual and gender identity disorders category of
DSM-IV-TR.
The debate continues as to whether paraphilias are best conceptualized as sexual disorders unto
themselves or are simply a special kind of obsessive disorder, anxiety disorder, or even addiction
disorder. Because they are sexually motivated behaviors and their phenomenology is experienced as
intensely driven eroticism, it seems appropriate to continue to classify them as sexual and gender
identity disorders, as in DSM-IV.

Types of paraphilias
While DSM-IV-TR does not classify paraphilias other than by erotic focus, it is clear from clinical
practice that they may be either exclusive or nonexclusive as well as egosyntonic or egodystonic.
Patients with the exclusive form of a paraphilia may not be able to be sexually aroused by anything
other than their paraphilic imagery or behavior. By contrast, patients with the nonexclusive form
may be aroused by other sexual fantasies, stimuli, and behaviors, although their paraphilias may
interfere with their overall sexual experiences.
Similarly, any given patient may find his or her paraphilia either congruent with his values and
beliefs or at odds with them. Persons with paraphilic phenomenology that does not disturb core
personal values are said to have egosyntonic paraphilias, while those who feel their sexual
phenomenology is wrong and is not congruent with their internal moral compasses are said to have
egodystonic paraphilias. Clearly, better treatment results can be expected with patients who have
paraphilias that are egodystonic.
Physicians and patients alike often wrestle with whether some seemingly harmless, egosyntonic
paraphilia (for example, fetishistic cross-dressing) should be viewed simply as different—part of the
rainbow of sexual diversity—or should be treated as pathological. Each case is different, but the
physician should be mindful that when, for example, an individual is driven by his paraphilic urges to
steal shoes or undergarments, the picture changes dramatically. Similarly, consensual bondage/
discipline, which some clinicians see as part of the sadism/masochism spectrum, may or may not
need to be treated depending on degree.

Comorbidity
The paraphilias do not always occur in the absence of other psychopathology. Many paraphilic
patients show evidence of major Axis I mental illnesses including affective disorders, substance
abuse disorders, schizophrenia, other psychotic disorders, dementia, and other cognitive disorders.
Paraphilias can occur within the context of Axis II disorders such as borderline or antisocial
personality disorders and mental retardation, and Axis III disorders, such as temporal lobe epilepsy
or brain trauma. For example, Mitchell and colleagues described the case of a patient with temporal
lobe epilepsy and transvestic fetishism whose paraphilic behaviors decreased following temporal
lobectomy. Similarly, Mendez and associates presented data on 2 men with right temporal lobe
hypometabolism and late onset pedophilia. In such cases it can be quite difficult to tease out the
discrete disorders; however, treating one co-occurring condition may not always render it
unnecessary to treat the other disorder.
For example, the pedophile who also has bipolar disorder may need different kinds of both
pharmacological and psychological intervention for each of the disorders. The paraphilia may need
to be treated with a testosterone-lowering drug such as leuprolide in conjunction with psychotherapy
such as relapse prevention therapy, while the mood disorder might require mood stabilizers and
other pharmacological agents in combination with cognitive-behavioral therapy. These combinations
are some of many that may be used in treatment modalities that recognize the need to treat each
co-occurring condition separately.
There are no reliable data with respect to the incidence of paraphilias and co-occurring mental
health conditions. The nature of these co-occurring disorders, however, in addition to the dangers associated with paraphilic disorders, has profound implications for treatment stratagems for the paraphilic component. In any event, patients with paraphilias who have a co-occurring condition will require psychiatric treatment for both the paraphilia and any other mental-health conditions.

**Cause**

The cause of paraphilias is unclear. Early theorists postulated that paraphilias, as well as other psychiatric conditions such as feeble mindedness, were part and parcel of brain degeneracy, a significant cause of which was overtaxing the nervous system by such phenomena as masturbation, or “nocturnal pollutions.” Degeneracy went hand in glove with “hereditary taint,” which was thought to accumulate through the generations. Although mechanisms were not clearly elucidated, exposure to excessive sexual stimulation outside socially sanctioned heterosexual marriage was believed to put individuals at risk for sexual deviations. Why such deviations developed in some individuals and not others was explained by the postulate that less tainted individuals were at less risk than more degenerate individuals for sexual perversions. Moreover, such excessive stimulation need not always be intentional. For example, one theory enjoying some degree of acceptance in early psychoanalytic circles was that infants born to hereditarily tainted mothers were predisposed to develop a fur fetish by coming into contact with their mother's pubic hair during birth (W. B. Pomeroy, personal communication; 1982). While such explanations seem naïve today, the notion that the development and maintenance of paraphilias must be a combination of genetic susceptibility and environmental trauma persists. In reality, we still know very little about the genesis of paraphilias.

The data that have been collected, however, do support at least 1 biological marker for vulnerability: men account for the vast majority of paraphilias. Among the paraphilias specifically delineated by DSM-IV, paraphilias are much more infrequently diagnosed in women than in men. Except for sexual masochism, which is still about 20 times less likely to affect men than women, paraphilias are quite unlikely to be diagnosed in women.

Paraphilias, or at least conditions that look very much like paraphilias, have also been reported as the result of brain trauma, neoplasms, temporal lobe damage, or epilepsy and may manifest as hyposexuality or hypersexuality, particularly in men. Lehne described a case of a frontal lobe injury in a man who suddenly developed a paraphilic interest in his stepdaughter's breasts. Treatment with conventional methods, including anticonvulsant administration, cognitive-behavioral therapy, and individual/family therapy failed to address his illness adequately but antiandrogens brought his symptoms under control.

**Treatment and prognosis**

Optimal treatment of the paraphilias entails some combination of psychologically and biologically based treatments, although it is not uncommon for therapists of some schools to rely solely on psychological interventions. Among the psychologically based techniques used in the treatment of persons with paraphilia, as well as nonparaphilic sex offenders, are group and individual cognitive and/or behavioral therapies and relapse prevention therapy.

The neurobiology of paraphilias is not completely understood, but pharmacotherapy directed at hormones (through their action on the hypothalamic-pituitary-gonadal axis) known to impact sexual arousal is often helpful in the management of paraphilias. Biologically based treatment includes agents that reduce testosterone levels, such as medroxyprogesterone (or cyproterone acetate outside the United States). More recently, there has been a switch away from medroxyprogesterone and cyproterone toward luteinizing hormone-releasing hormone agonists such as leuprolide. The tendency to keep pharmacological treatments in reserve for refractory cases when the psychologically based therapies seem ineffective appears to be giving way to using pharmacotherapy as a first-line adjunct to therapy.

A discussion of treatment would be incomplete without acknowledging concerns about countertransference. In the treatment of persons with paraphilia in general, and particularly with those whose behaviors arising from paraphilic ideation are illegal, it has been commonplace to define countertransference as emotions experienced by a treatment provider that may interfere with the delivery of appropriate patient care. The treatment of a patient for paraphilia may be compromised by the feelings and negative opinions of a clinician toward the patient. For effective treatment to occur, a treatment provider must be aware of countertransference and be capable of keeping it in check. While a patient with paraphilia may provoke a range of emotional responses ranging from boredom to amusement or anger in the treating clinician, such personal responses may be quite damaging if they spill over into the treatment process. Not all treatment providers want to work with a pedophile or a necrophile; however, those who attempt this difficult
task should be scrupulously honest with themselves with respect to whether they can be competent and comfortable working with these patients.\textsuperscript{10}

**Forensic considerations**

Simply having paraphilia is, obviously, not illegal. Acting in response to paraphilic urges, however, may be illegal and in some cases subjects the person with paraphilia to severe sanctions. The distinguishing phenomenological characteristic of paraphilias is an intense craving or urge to fantasize or engage in some form of sexual expression that most people would not find erotic. Most people simply do not experience such cravings. These urges are often difficult and, in some cases, may even be impossible to control. It is this putative lack of impulse control that underlies the insanity defense in trials alleging sexually criminal behavior. Such defenses are based on impaired mental capacity and are sometimes, although infrequently, successful.

The importance of these distinctions, particularly the phenomenology of paraphilias, cannot be overemphasized: sex offenders are not necessarily persons with paraphilia and persons with paraphilia are not all sex offenders. Forensic considerations aside, it is quite possible to be a person with paraphilia on the proverbial desert island without becoming a sex offender.

It is also crucial to recognize the differences between working in the forensic arena and more conventional treatment settings. Treatment providers who are not comfortable with the adversarial nature of forensic psychiatry and the milieu of the courtroom may be reluctant to treat patients with paraphilia who are also sex offenders.

**Conclusion**

While neither the causation of nor the specific modes of action of the various modalities for managing the paraphilias are well understood, evidence suggests that treatment is worthwhile, both in reducing the rate of recidivism and subsequent danger to society from sex crimes and in relieving the suffering of individuals with paraphilias and comorbid conditions. It seems well worth the efforts of psychiatrists to continue to refine both their diagnostic and treatment skills toward this end.

**References:**


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