SYMPOSIUM ON SEXUAL DEVIATION

Paraphilias

Sadomasochism, Fetishism, Transvestism and Transsexuality

J. R. W. CHRISTIE BROWN

Particular instances of sexual deviation can not be discussed sensibly without first considering certain general issues.

The first of these is the question of definition. The notion of what constitutes abnormal sexual behaviour has changed in the course of history and indeed its boundaries have expanded and contracted at different times. What emerges from the history of the concept is that it has been defined by the social and moral climate of the time and indeed sexual deviance can be seen, for the most part, as a social rather than a medical concept (Bancroft, 1974). There may well be a core of extremely deviant behaviour that has always been considered abnormal, but considerable changes in attitudes have taken place even in this century. For example, Krafft-Ebbing (1906), who said of adultery that "the unfaithfulness of the wife, as compared to that of the husband, is morally of much wider bearing and should always meet with severer punishment at the hands of the law", defined sexual deviance (perversion) as "every expression of (the sexual instinct) that does not correspond with the purpose of nature—i.e. propagation". In the more gentle climate of the 1980s, the American Psychiatric Association Task Force said of the paraphilias that "the essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement". (DSM III, 1980). A slightly sharper and modern European definition is that of Scharfetter (1980): "non-coital sexual behaviour on the part of sexually mature individuals may be called abnormal only when it is practised not just as an introduction to or an accompaniment of coitus but, despite opportunities for coitus, as the exclusive or preferred form of behaviour". This is not a view that would be enthusiastically espoused by the partners of some sexually unusual persons.

The second general issue is that of case selection, a matter that is often recognised in theory but forgotten in practice. Clinicians only study those who come to see them and many factors, some unknown, define who comes and who does not from a population sharing a certain disorder. The 'clinical' population may well differ in important respects from the others and conclusions, particularly where they concern aetiology, based on the study of clinical samples may well be wrong. The is no satisfactory epidemiology of sexual deviance and representative samples are particularly hard to find for obvious reasons. The social climate, which has much to do with the definition of deviance, also influences the presentation of deviant people in clinics.

Finally there is the question of the relationship of the paraphilias to each other and to normal behaviour. Krafft-Ebbing (1906) and others seemed to equate sexual deviance with disease and described particular forms of deviance as if they were specific illnesses. Our present system of classification, useful though it may be, tends to sustain this view, but in recent years an alternative nosological approach has gained ground. This is based on the notion that sexual deviance shades off into normal behaviour in a continuous fashion and that there is a similar relationship between different types of deviance, these types being no more than convenient fixed points. There are good reasons for giving support to the newer dimensional rather than the older categorical model.

A hint of this can be found in the Glossary to ICD 9 where it is said that "it is common for more than one deviation to be found in the same individual". Indeed in clinical practice, patients with more than one deviation or 'intermediate' or 'mixed' presentations are common. Furthermore, Kinsey *et al* (1948) showed not only that 37 per cent of their male subjects had had some homosexual experience leading to orgasm in their lives, but also that there was a fairly smooth gradation from incidental or occasional homosexuality, which was relatively common, through to exclusive homosexuality, which was relatively rare. Lastly it is known that people who are considered normal have sexual fantasies of behaviour that, if acted out, would be considered deviant (Crepault and Couture, 1980).

There is no generally established scheme of the dimensions of sexuality. It is convenient to follow Whalen (1966) and, adapting his scheme slightly, to propose that normal sexual variation can be described in terms of variation along four dimensions as follows:

1. The gender identity and role behaviour of the individual.
2. The 'object choice' or direction of sexual preference.
3. The characteristic rate of arousability of the individual.
4. The level of arousal obtained.

https://doi.org/10.1192/bjp.143.3.227 Published online by Cambridge University Press

5. The amount or frequency of sexual activity.

This scheme can also be applied to the description of sexual deviations and disorders which can be seen as cases of extreme variation on one or more of these dimensions.

These introductory remarks may now be summarised. Definitions of sexual deviance reflect the norms of the particular society in which they occur rather than any fixed medical criteria. Deviant individuals are best seen as lying towards the extremes of one or more dimensions along which are also distributed the rest of the population. Information about sexual deviance is distorted by virtue of being mainly based on the study of clinical populations. Such populations usually consist either of those who are distressed by their predilections or whose partners are or who present medico-legal problems.

All these patients, but particularly the last group, present difficult ethical problems. In general, treatment should only be based on a therapeutic contract to which the patient is an informed and willing party.

Four types of sexual deviation from the standard classifications will now be discussed.

Sadomasochism

Sadism may be defined as the obtaining of sexual satisfaction from causing pain, injury or humiliation to others and masochism as obtaining satisfaction from being the recipient of these. In the general psychiatric clinic such cases are rarely seen and in the literature are considered to be rare; extreme cases come to light in the Courts when serious injury or death occurs. Because sadism and masochism usually occur together in the same individual, it is convenient to join the two as sadomasochism. As with other deviances, it is more common in men than in women, but with a tendency for men to show a preponderance of sadism and women of masochism.

Although extreme forms of sadomasochism seem far removed from normal sexuality, Crepault and Couture (1980) identified factors of aggressiveness and masochism in an analysis of the sexual fantasies of 94 normal males. Gosselin and Wilson (1980) studied, mainly by questionnaire, non-clinical groups of male sadomasochists, fetishists, transvestites and transsexuals all contacted through societies or correspondence clubs catering for them; a normal control group was also included. Unfortunately this interesting study is marred by the methodological problems that seem inevitable in this kind of work. First, the members of the different groups are self-selected and no independent defining criteria can be applied. Secondly, the response rates were very low; for example only 125 out of a possible 1200 fetishists and 133 of a possible 600 sadomasochists responded. They reported that the sadomasochists studied were able to contain their activities to forms acceptable to their partners with whom they had otherwise reasonable relationships. There was considerable overlap between their preferred fantasies and activities and those of the fetishists and transvestites. Within the sadomasochistic group, there was considerable overlap between sadism and masochism but with the latter predominating. All their groups scored more highly on introversion and neuroticism than controls; these differences were smallest for sadomasochists and greatest for transvestites with the fetishists coming in between. They propose a learning theory model of the development of deviation based on the idea that 'deviant stimuli', experienced by chance at times of high arousal in childhood, readily set up conditioned responses of arousal in more introverted subjects and that a restrictive upbringing can prevent the extinction of these responses.

There is no specific treatment for sadomasochism as distinct from other deviations. Dynamic psychotherapy and behaviour therapy have their advocates, the second having gained much ground in recent years. In dangerous patients anti-androgens may be useful, cyproterone acetate being favoured in Europe and medroxyprogesterone in the USA (Berlin and Meinecke, 1981). Supposedly voluntary surgical castration has been in use in West Germany (Heim, 1981) for sex offenders of various types, as has psychosurgery. The usual operation was the destruction of the ventromedial nucleus of the hypothalamus on the non-dominant side and good results were claimed in the 74 men and one women with various sexual deviances who had been operated on by 1976. Two thirds of these patients were at the time in prisons or mental hospitals. The critics (Rieber and Sigusch, 1979; Schmidt and Schorsch, 1981) not only returned a resounding 'not proven' verdict on the results but attacked the shaky theoretical basis for the operation, the poor quality of the assessments and the questionable ethics of the whole business. Faced with a public outcry and a Government enquiry, the surgeons gave up. If anything is to be salvaged from the wreckage, it includes a sense of relief at the reaffirmation that humans and rats are different and a conviction that much more research is needed into the brain mechanisms controlling sexual behaviour.

Fetishism

Strictly, fetishism means the worship of inanimate objects but when given a sexual connotation may be defined as 'the use of non-living objects as a repeatedly preferred or exclusive method of achieving sexual excitement'. (DSM III, 1980). Perhaps because fetishism is an unassuming and private activity in most

instances, cases are exceptionally rare in clinical populations and little is known about them except that the vast majority are male. Gosselin and Wilson (1980) included rubber and leather fetishists in the study mentioned earlier. They found that 69 per cent and 66 per cent respectively of the respondents in these two groups had steady partners compared with 78 per cent among the controls. This might be in line with the theoretical contention of psychoanalysis that fetishism is the result of a developmental disturbance leading to sexual interest in symbolic objects rather than real people but the data can not be interpreted with any confidence.

Temporal lobe abnormalities may be specifically associated with various sexual abnormalities (Hoenig and Kenna, 1979), with hyposexuality perhaps being a linking factor (Shukla *et al,* 1979). Most striking is the report of Mitchell *et al* (1954) of three cases of fetishism associated with temporal lobe epilepsy and relieved by temporal lobectomy.

Transvestism

Transvestism is best seen as bridging the gap between fetishism and transsexualism and may be defined as obtaining sexual pleasure from dressing in the clothes of the opposite sex, or 'cross-dressing'. Nearly all patients so classified are male and most are heterosexual although DSM III (1980) narrows the category by insisting on maleness and heterosexuality as defining criteria. Typically, soon after puberty the patient begins to masturbate while wearing women's underclothes; the practice may stop there or develop into the wearing of full clothing, make-up and wig for private masturbation. Later, forays into public places or movement into a transvestite subculture may occur, with the original sexual excitement being attenuated or lost. Finally in some cases the patient may begin to seek some more permanent transformation into a female role. In this way, what begins as a 'simple' fetish may end up as something close to transsexualism. It may well be that those who show this progression have always had some transsexual features, but retrospective falsification of the history is a particular danger with these cases. In transvestism which has not so developed, treatment is most often sought at the instigation of the spouse. Behaviour therapy is the most important component in the treatment plan.

Transsexualism

Transsexualism stands out among the paraphilias for three reasons. First, although its true incidence is unknown, men out number women in the clinic by 2 or 3 to 1. Secondly, patients are vociferous in demanding medical treatment and at that treatment which seems aimed at promoting the disorder. Finally, transsexualism is currently the object of intense popular interest and publicity.

There is no satisfactory definition of transsexualism, but at its core is a disturbance of gender development typically manifested before puberty. The male patient, for example, reports having preferred from early childhood the company and activities of girls and having hoped to grow up to become a girl. This experience is later often expressed in the cliché of being a woman trapped in a man's body. Phenomenonologically such statements represent neither delusions nor obsessions. They are best understood as wishes.

The most convincing transsexuals show other features. They express great distaste for their genitalia and secondary sex characteristics; they show little interest in sexual activity but are attracted to others of the same anatomical sex while insisting that they are not homosexual; they adopt the behaviour and dress of the opposite sex, but in their cross dressing show no sexual arousal and no particular interest in underwear.

Such patients are usually seeking hormone treatment and surgery to make them correspond as far as possible to the anatomy of the opposite sex. However, in any clinical group of patients requesting 'sex change', only a minority conform convincingly to this 'core' pattern. For example, in some cases the transsexual picture has developed by way of transvestism; in some quite strong sexual interests, including heterosexual ones, have been displayed; in yet others the gender disturbance is relatively mild. A few patients displaying gross personality disorders dip into transsexualism as one adventure among many. Occasionally schizophrenic patients with delusions of sex change may present in this way but clearly they can not be considered as transsexuals. Meyer (1974) has devised a subclassification for these variants, but a dimensional view seems more helpful than a typology.

It is generally found that transsexuals attending clinics show a high rate of other psychiatric disturbance falling into the neurotic or personality disorder categories so that they are similar in this respect to a psychiatric out-patient population (Strassberg *et al,* 1979). It is not possible to say if these other disturbances are secondary to the transsexualism or independent, but their severity is an important consideration in planning treatment.

It seems reasonable to assume that the aetiology of the condition is multifactorial, and it can safely be said that it remains a mystery. Transsexualism has been found in widely different cultures and recorded throughout history, while at the same time cultural differences influence rates of presentation (Ross *et al,* 1981). There are usually no chromosomal abnorm-

alities in these patients and no strong support for the notion that early endocrine influences or specific family constellations are important. Interest in a genetic factor has recently been revived by the finding that a high proportion of male transsexuals lack the H-Y antigen normally found in males while female patients unexpectedly have this antigen (Engel *et al*, 1980; Spoljar *et al*, 1981). It is possible that these findings may have been produced by hormones being taken by the patients. EEG abnormalities, particularly involving the temporal lobes, have been reported (Hoenig and Kenna, 1979).

A programme of treatment for suitable cases has emerged over the last twenty years which is accepted in most centres. Male patients are given oestrogens which reduce libido and which may produce some breast development and softening of body hair; female patients are given testosterone which causes growth of hair and may suppress mentruation and deepen the voice. Surgery then follows. Males have the penis and testes removed with the construction of labia from the redundant skin, and vaginaplasty; they may also have breast augmentation. Females undergo bilateral mastectomy and sometimes phalloplasty, the construction of a penis of sorts. The technical results of this last procedure are very variable (Noe *et al*, 1978).

This process can not be contemplated without a sense of alarm. How can it be justified? There are two standard answers. First, no other treatment helps the patient. Against this there have been a few reports of doubting transsexuals being helped to revert to a normal gender role by behavioural programmes (e.g. Barlow *et al*, 1979). Secondly it is claimed that the usual treatment programme by hormones and surgery satisfies patients and increases their general well-being. The results of treatment have been critically reviewed by Lothstein (1982). In general the quality of follow-up studies has been very poor and earlier claims of 95 per cent "success rates" now seem excessive. Nevertheless the standard treatment seems to be the best solution in a proportion of cases. In practice, how are suitable cases selected? First, an adversarial approach by the doctor will simply strengthen the patient's resolve to 'change sex' while a gentler and more accepting attitude will allow doubts to be expressed. Next, the more closely the patient corresponds to the picture of 'core' transsexualism, the more likely is the role change to be successful; similarly good general adjustment and relative freedom from neurotic and personality disorders point to a good outcome. Conversely enjoyment of sexual activity and unconvincing appearance in the chosen role suggest a poor outcome. In practice, when suitable cases have been selected, the 'two year real-life test' (Money and Ambinder, 1978) must be applied. This means that the patient must live fully in the chosen role for at least two years before any surgery is contemplated. If the patient copes well, resolves the attendant social and personal difficulties and demonstrates improved general adjustment, then surgery is likely to be followed by increasing satisfaction.

Of course more research is needed. In this perplexing field there are many leads to be followed up but the outstanding need is for widely agreed and reliable criteria and measurements to be applied both to assessment and follow-up.

References

BANCROFT, J. (1974) *Deviant Sexual Behaviour*. Oxford: Clarendon Press.

BARLOW, D. H., ABEL, GENE, G. & BLANCHARD, EDWARD B. (1979) Gender identity change in transsexuals: Follow-up and replications. *Archives of General Psychiatry*, **36**, 1001–7.

BERLIN, FRED S. & MEINECKE, CARL (1981) Treatment of sex offenders with antiandrogenic medication; conceptualisation review of treatment modalities and preliminary findings *American Journal of Psychiatry*, **138**, 601–7.

CREPAULT, CLAUDE & COUTURE, MARCEL (1980) Men's erotic fantasies. *Archives of Sexual Behaviour*, **9**, 565–81.

DSM III (1980) *Diagnostic and Statistical Manual of Mental Disorders*. American Psychiatric Association.

ENGEL, WOLFGANG, PFAFFLIN, FRIEDMANN, & WIEDEKING, CLAUS (1980) H-Y antigen in transsexuality and how to explain testis differentiation in H-Y antigen negative males and ovary differentiation in H-Y antigen positive females. *Human Genetics*, **55**, 315–19.

GOSSELIN, CHRIS & WILSON, GLENN (1980) *Sexual Variations* London & Boston: Faber & Faber.

HEIM, NICKOLAUS (1981) Sexual behaviour of castrated sex offenders. *Archives of Sexual Behaviour*, **10**, 11–19.

HOENIG, J. & KENNA, J. C. (1979) EEG abnormalities and transsexualism *British Journal of Psychiatry*, **134**, 293–300.

KINSEY, A. L., POMEROY, W. B. & MARTIN, C. E. (1948) *Sexual Behaviour in the Human Male*. Philadephia: Saunders.

KRAFFT-EBBING, R. VON (1906) *Psychopathia Sexualis*. 12th edition. London: Heinemann.

LOTHSTEIN, L. M. (1982) Sex reassignment surgery—historical bioethical and theoretical issues. *American Journal of Psychiatry*, **139**, 417–26.

MEYER, JON K. (1974) Clinical variants among applicants for sex reassignment. *Archives of Sexual Behaviour*, **3**, 527–58.

MITCHELL, W., FALCONER, M. & HILL, D. (1954) Epilepsy with fetishism relieved by temporal lobectomy. *Lancet*, **ii**, 626–30.

MONEY, JOHN & AMBINDER, RICHARD (1978) Two year, real-life diagnostic test; rehabilitation versus cure. In *Controversy in Psychiatry*. (eds. J. P. Brady and H. K. H Brodie). Philadephia: Saunders.

NOE, JOEL, SATO, RONALD, COLEMAN, CLIFFORD & LAUB, DONALD R. (1978) Construction of male genitalia; the Stanford experience. *Archives of Sexual Behaviour*, **7**, 297–304.

RIEBER, INGE & SIGUSCH, VOLKMAR (1979) Psychosurgery on sex offenders and sexual 'deviants' in West Germany. *Archives of Sexual Behaviour*, **8**, 523–7.

ROSS, M. W., WALINDER, B., LUNDSTROM, B. & THUWE, I. (1981) Cross cultural approaches to trans-sexualism. A comparison between Sweden and Australia. *Acta Psychiatria Scandinavica*, **63**, 75–82.

SCHARFETTER, CHRISTIAN (1980) *General Psychopathology*. Cambridge University Press.

SCHMIDT, GUNTER & SCHORSCH, EBERHARD (1981) Psychosurgery of sexually deviant patients: review and analysis of new empirical findings. *Archives of Sexual Behaviour*, **10**, 301–23.

SHUKLA, G. D., SRIVASTAVA, O. N. & KATIYAR, B. C. (1979) Sexual disturbances in temporal lobe epilepsy. *British Journal of Psychiatry*, **134**, 288–92.

SPOLJAR, MARIJAN, EICHER, WOLF, EIERMANN, WOLFGANG & CLEVE, HARTWIG (1981) H-Y antigen expression in different tissues from transsexuals. *Human Genetics*, **57**, 52–7.

STRASSBERG, DONALD S., ROBACK, HOWARD, CUNNINGHAM, JEAN, MCKEE, EMBRY & LARSON, PAUL (1979) Psychopathology in self-identified female-to-male transsexuals, homosexuals and heterosexuals. *Archives of Sexual Behaviour*, **8**, 491–6.

WHALEN, RICHARD E. (1966) Sexual motivation. *Psychological Review*, **73**, 151–63.

J. R. W. Christie Brown, M.A., M.R.C.P., F.R.C.Psych., *Consultant Psychiatrist, The Maudsley Hospital, London SE5 8AZ.*

SYMPOSIUM ON SEXUAL DEVIATION

Exhibitionism: A Clinical Conundrum

PHILIP SNAITH

Genital exhibitionism is a disorder without a satisfactory explanation; many views have been put forward as to its nature but although fragments of some of these theories appear to be relevant to the problems of some individuals, for others they are incongruent with the clinical data. At the present time we must conclude that the behavioural act does not signify a homogeneous population and that in every parameter so far studied, be it personality structure, attitude to women, erotic gratification from the act, other deviant behaviour or whatever, there is no single unifying characteristic which is always to be found. The intention in this paper is not to make a broad survey of the disorder for that has been undertaken within the last fifteen years by, inter alia, Evans (1970) and Rooth (1971, 1980); the purpose is to draw attention to some of the more recent studies in order to dispel stereotyped views and thereby to avoid the pitfalls in deriving the formulation of each individual case.

Definition

Exhibitionism is the commonest of the offences legally classified as indecent exposure; in fact it is probably the commonest of all sexual offences and whatever quirks of constitution or psychological development are operative in its causation must therefore affect a large number of men. It may be defined as the display of the penis to another person or persons outside an intimate relationship and as a limited act without further progress toward assault or intercourse being intended or desired.

The display may be done discreetly as from behind a net curtain in a house to a passer-by in the street or it may be a wild-seeming event, for instance, springing out naked from behind a bush or a tree; the penis may, or may not, be erect and there may or may not be an erotic component (in fact although classified, for obvious reasons, as a 'sexual' offence, it does not always subserve an erotic need). The 'victim' may be