

## ABC of sexual health

### Sexual variations

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“Sexual variations” refer to sexual desires and behaviours outside what is considered to be the normal range, although what is unusual or atypical varies between cultures and from one period to another. Defining normality is extremely difficult (and arbitrary), because the definition involves making a value judgment and therefore labelling how we view other people.

Sexual variations are also referred to as paraphilias, a neutral term for behaviours formerly called deviant. They can be defined as conditions in which a person’s sexual gratification is dependent on an unusual sexual experience revolving round particular sex objects.<sup>1</sup> They are much more common in men than women.

### History and culture

Sexual variations have existed and been recorded for millennia in different parts of the world. For example, early Buddhist texts contain numerous references to sexually variant behaviours among monastic communities over 2000 years ago. These behaviours included sexual activity with animals and sexual interest in corpses.

In the clinical literature sexual variations had begun to be extensively discussed by the second half of the 19th century. The classic example is Richard von Krafft-Ebing’s *Psychopathia Sexualis*, first published in 1887. In this book the author, a neuropsychiatrist, details, among others, fetishism, flagellation, sadism, necrophilia, sadistic acts with animals, masochism, exhibitionism, bondage, paedophilia, bestiality, and incest.

### Major sexual variations

*Exhibitionism* is among the most common of the sexual variations. The usual image is of a middle aged man in a dirty raincoat “flashing.” Typically, however, exhibitionists are postpubescent males up to the age of 40 who obtain high levels of sexual pleasure and excitement from exposing their genitals to females, usually strangers, and who may masturbate at the same time.

*Paedophilia* involves intense sexual urges and sexual activity with prepubescent children. Two thirds of molested children are girls, usually between the ages of 8 and 11. To meet the diagnostic criteria, a paedophile must be at least 16 years old and at least five years older than the victim. Most paedophiles are men, but there are cases of women having repeated sexual contact with children. In 90% of cases the molester is known to the child, and 15% (possibly more) are relatives. Most paedophiles are heterosexual and are often married with their own children, although they commonly have marital or sexual difficulties or problems with alcohol misuse. Eighty per cent have a history of childhood sexual abuse.

*Fetishism* involves recurrent sexual urges or behaviours concerning the use of inanimate objects such as leather and rubber garments, women’s underwear, stockings, and shoes and boots.

*Transvestism* refers to recurrent, intense sexually arousing fantasies, urges, and behaviours involving cross dressing. A transvestite is a heterosexual male who derives sexual satisfaction by wearing female clothing. Many are married and



#### A case example of fetishism from Krafft-Ebing (1887)

Z began to masturbate at the age of 12. From that time he could not see a woman’s handkerchief without having orgasm and ejaculation. He was irresistibly compelled to possess himself of it. At that time he was a choir boy and used the handkerchiefs to masturbate within the bell tower close to the choir. But he chose only such handkerchiefs as had black and white borders or violet stripes running through them. At age 15, he had coitus. Later on he married. As a rule, he was potent only when he wound such a handkerchief around his penis. Often he preferred coitus between the thighs of a woman where he had placed a handkerchief. Whenever he espied a handkerchief, he did not rest until he was in possession of it. He always had a number of them in his pockets and around his penis



seem very masculine. They should not be mistaken for female impersonators on the stage (such as “Dame Edna Everage”) or male homosexuals who cross dress (“go in drag”), who are not sexually aroused or dependent on their cross dressing for sexual excitement.

*Transsexualism* is not, strictly speaking, a paraphilia but rather an issue of gender role. Transsexuals have an intense desire to become a member of the opposite sex, feeling that they are trapped in the “wrong body.” Many therefore ask for surgical intervention for a sex change. Transsexualism is found equally in males and females, and they should not be confused with transvestites, who cross dress for sexual arousal but who do not want anatomical change.

*Hypoxyphilia* is an increasingly commonly reported variation that involves attempts to enhance the pleasure of orgasm by a reduction of oxygen intake—for example, by placing a tight noose around one’s neck. Such behaviour has led to fatalities.

*Other sexual variations* include gaining sexual pleasure from inflicting pain (sadism) or from suffering pain or humiliation (masochism), sexual desire for corpses (necrophilia) or for animals (zoophilia or bestiality), arousal from contact with urine (urophilia) and faeces (coprophilia), and excitement from rubbing the genitals against a clothed person in a confined space such as the Underground (frotteurism).

*Combinations*—It is not unusual for an individual to have more than one sexual variation. The commonest combination is fetishism, transvestism, sadism, and masochism.

## Clinical presentations

Sexual variations seen in clinical settings are only a proportion of the cases where such problems exist. There are, broadly speaking, four classes of clinical referral.

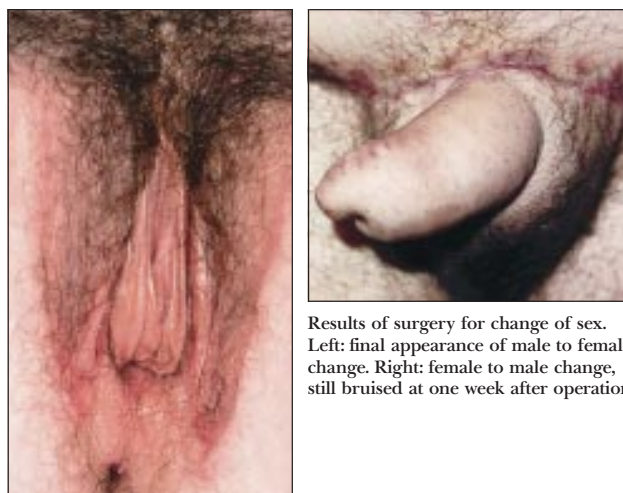
- Those sent for clinical intervention by the law enforcing authorities. These are sex offenders who are asked to have treatment to help them overcome their problem behaviour.
- Those who seek help for their sexual variations because they are distressed by them. These include people who worry that they might commit illegal or embarrassing acts. Many are distressed by acts they see as “unnatural” or are afraid that they may endanger their life or their career.
- Those who seek help because their partners are distressed by the sexual variation. They are themselves distressed because of their partner’s distress. These are people with stable or long term relationships.
- Those who present with frank sexual dysfunction. They report erectile difficulties or other dysfunctions, which are usually secondary to strong variant desires and reliance on these for arousal. For example, a man may find that he is unable to sustain an erection for sexual intercourse with his partner unless he has contact with, say, a leather garment.

### Assessment

Clinical assessment in these cases needs to be comprehensive, with information elicited about a number of aspects. Such a detailed assessment gives the clinician a full picture of the problem, and enables him or her to plan a suitable intervention.

## Treatment

The aims of treatment must be carefully considered, and the therapist and the client need to arrive at an agreed goal. Until about 20 years ago, most patients were treated with one aim only—to eliminate their variant sexual arousal. The main technique used was electrical aversion therapy. This often suppressed the problem behaviour but did not eliminate it.



Results of surgery for change of sex. Left: final appearance of male to female change. Right: female to male change, still bruised at one week after operation



People may seek help for their sexual variations because their partners are distressed by the variation

### Assessment of sexual variations—aspects to be explored

- Variant arousal
- Sexual fantasies
- If there is a problem in arousal in relation to conventional stimuli, for example, consenting adult partners
- Anxiety about conventional sexual activity
- Anxiety about social interactions with adults, especially those of the same age group and who are potential sexual partners
- Difficulties with social interactions
- Problems with conventional adult sexual activity
- Whether the person has a problem with his or her gender role

**Treatment of sexual variations is difficult. After careful assessment, treatment goals must be established, and, to achieve these, a comprehensive therapeutic package is usually needed. Focusing on the variant arousal is only one aspect of treatment, and therapy that takes this as the sole focus is rarely successful**

If the goal of treatment is to eliminate the sexual variation, it must be recognised that success may be limited. Control may be achieved, but this needs to be supplemented with gains in other, more acceptable, sexual behaviours. In practice, this means that any treatment programme that includes an attempt to get rid of the variation must also include enhancement of other outlets. Other sexual anxieties or skills deficits need to be addressed.

**Incorporation**

An alternative to elimination is to incorporate the variation in a controlled way into the person's sexual repertoire. This is especially so in the case of people whose partners are distressed by the dominant role of the variation in their sexual behaviour. Obviously, this is not possible if the variation is unacceptable, such as paedophilia. It is also important that the variation is something the partner can tolerate in a limited way.

In practice, the therapist will use a multifaceted therapy programme. One aspect of such a programme is conventional sex therapy, aimed at enhancing the sexual relationship. In further joint work, the couple are helped to systematically reduce the role of the variation in their sexual relationship. For example, a man with a rubber or leather fetish may be asked to wear only a leather arm band during sex. Similarly, temporal control may be introduced, using a timetable approach. The couple agree, for example, to use the fetish object in their sexual relations on certain days of the week only.

**Group therapy**

Some clinics operate group therapy programmes. These are most commonly used for sex offenders. The programmes involve group processes and group learning.

**Chemical treatment**

For those with serious difficulties, chemical treatment is sometimes considered. Reduction of the sex drive through drugs will, of course, reduce the problem behaviour, but its effectiveness is not selective: that is, the drive is dampened down in toto, not just the desire for the variant behaviour. The drugs commonly used are medroxyprogesterone acetate and cyproterone acetate.

**Orgasmic reconditioning**

This approach has been used since the 1970s, and its main feature is the reinforcement of conventional arousal and desires. Typically, the patient is asked to masturbate with his variant fantasy and then, when orgasm is imminent (the point of no return), to switch to a fantasy of a conventional sexual stimulus or behaviour. The ensuing orgasm then powerfully reinforces the conventional desire. In succeeding sessions (which the client carries out in privacy) the point when the switching is made is brought forward so that, eventually, the entire sequence takes place to conventional fantasies.

**Aversion therapy**

Electrical aversion involves the repeated pairing of the variant stimulus (such as pictures projected on a screen) with an unpleasant stimulus (electric shock). The use of this procedure is now uncommon. A related procedure is covert sensitisation. Here, the aversion is covert and imagined. The person is asked to fantasise a sequence of events involving his or her variant behaviour and, at a crucial point of the sequence, to imagine a powerful aversive scene. For example, a paedophile might be asked to imagine the appearance of a police officer at the point of his approaching a child in his sequence of images. The aversive scenes are agreed in advance, and typically more than one aversive consequence is used.



In couple therapy a man with a leather fetish may be encouraged to reduce his use of the fetish to a level more acceptable to his partner



With orgasmic reconditioning, a man is asked to change his variant fantasy to one of conventional sexual behaviour while masturbating. (Detail of *Phyllis Riding Aristotle* (1513) by Hans Baldung Grien)

The photographs of a transvestite, by Anne Maniglier, and a man wearing leather gear, by Gordon Rainsford, are reproduced with permission of Gaze International. The cartoon "You don't often see a real silk lining..." is reproduced with permission of Punch Publications. The cartoon "More, Angela, more" is reproduced with permission of Tony Goffe.

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1 Masters WH, Johnson VE, Kolodny RC. *Human sexuality*. 5th ed. New York: Harper Collins, 1995.

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