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# Paraphilia and Fetishism

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*Atypical sexual behavior is intriguing to many people, yet the empirical research on paraphilia and fetishism is relatively lacking. Nonetheless, clinicians are often called on to intervene in such cases, particularly when the paraphilia involves nonconsenting partners. This review article is structured around a brief historical overview of the diagnostic classification of atypical sexual behavior in the United States, descriptions of the types of atypical sexual behavior that receive clinical attention, an overview of the models that have been proposed to explain the development of atypical sexual behavior, and finally a summary of the most common treatments for these problems.*

**Keywords:** *paraphilia; fetishism; sexuality; sex therapy*

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Sexual deviance has long held the public's attention and aroused people's curiosity. People seem forever intrigued by what peculiar sexual activities others might perform. If you find yourself reading this article at the expense of other articles in this issue of the journal, perhaps it is because of the curiosity surrounding this topic, and it just shows you are human. Given the apparently high human interest, it might seem plausible that a large army of researchers would be working to further the collective understanding of sexual deviance. It might be surprising, then, to learn the reality. Relatively little empirical work has been done regarding unusual sexual activities and preferences, and precious little is known for sure in this area. Perhaps part of the reason for the comparative lack of research attention is the common assumption that sexuality researchers investigate topics of personal relevance, and presumably few researchers want to be thought of as sexual deviants (Okami, 2002).

The phenomena reviewed here fall under the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association [APA], 1952, 1980, 1987, 1994) classification of *atypical sexual behavior*. The term sounds generic and seems to refer to sexual behavior that is statistically in the minority. However, there is more to the story. Certainly, there are many sexual behaviors that are not part of the statistical norm as to what people tend to "do" sexually. The key to being a disorder is that the sexual behavior in question

results in subjective distress or impairment in the individual's functioning or it involves nonconsenting partners. In practice, the diagnosis of atypical sexual behavior can be ambiguous and controversial. The remainder of this article is structured around a brief historical overview of the diagnostic classification of atypical sexual behavior in the United States, descriptions of the types of atypical sexual behavior that receive clinical attention, an overview of the models that have been proposed to explain the development of atypical sexual behavior, and finally a summary of the most common treatments for these problems.

## HISTORICAL CONTEXT

The term *paraphilia* was coined by Stekel (1924). The first part of the word, *para*, translates as "other" or "outside of," as in the term *paranormal*, and *philia* is defined as "loving." So, the term *paraphilia* translates loosely into loving something outside of the norm or love of the perverse. Of course, one can ask, "What does love have to do with it? Aren't we talking about lust or sex?" Perhaps the term *paraphilia* is a misnomer. Moser (2001) proposed that a more accurate term would be *paralagnia*, because *lagnia* translates into "lust." In any case, the term *paraphilia* was popularized by Money (1980, 1984) as a nonpejorative designation for unusual sexual interests and became part of the *DSM* in the 1980 edition (APA, 1980).

Some writers have pointed to the potentially dubious nature of paraphilia as a clinical diagnosis. For example, Moser (2001) proposed that pathologizing atypical sexual interests is merely a method of social control of sexual behavior. There is little controversy over the observation that what is considered normal or acceptable sexual behavior varies according to the culture, historical period, dominant political party, and so forth. Accordingly, the diagnosis of atypical sexual behavior has undergone revision over the 50 years the *DSM* has existed. In the first edition of the *DSM* (APA, 1952), the diagnostic category was listed as "sexual deviation." Five particular forms of sexual deviation were noted: homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (pp. 38-39). The second edition of the *DSM* (APA, 1968)

retained the designation “deviant sexuality” but now specified the following: “This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances” (p. 44). What was considered “bizarre” may very well have been a value judgment on the part of the clinician, and presumably masturbation or oral sex could have been included in this definition of “deviant sexuality.” Perhaps to qualify this assumption, there was the additional criterion that individuals experiencing sexual deviations “remain unable to substitute normal sexual behavior for them” (p. 44).

The third edition of the *DSM* (APA, 1980) included the term *paraphilia* and emphasized that a defining characteristic was that the “unusual or bizarre imagery or acts are necessary for sexual excitement” (p. 266). In other words, the individual with paraphilia was defined by a reliance on deviant stimuli to attain sexual arousal. By the time the third edition of the *DSM* was revised (APA, 1987), however, research had shown that individuals with diagnosed paraphilia were often responsive to normative sexual stimuli as well (Moser, 2001). The criterion that deviant sexual imagery or acts were necessary for sexual arousal was dropped in favor of reference to a sexual arousal pattern that is “not part of normative arousal activity patterns and . . . may interfere with the capacity for reciprocal, affectionate sexual activity” (APA, 1987, p. 279). Determining what “normative arousal activity patterns” are, and then using those as the standard for making a judgment of sexual deviance, was potentially problematic (McDougall, 1992).

The fourth edition of the *DSM* (APA, 1994) provided a major change, and many might say an improvement (e.g., Moser, 2001), by specifying that “a paraphilia must be distinguished from the *non-pathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement*” (p. 525). According to the fourth edition of the *DSM* (APA, 1994), the essential clinical features of paraphilia are

recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one’s partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months. (pp. 522-523).

The second criterion is that these fantasies, urges, or behaviors cause significant distress or functional impairment. Several particular types of paraphilia are provided as specific diagnoses. Each will be described in the next section.

## TYPES AND FEATURES OF PARAPHILIA

An interesting feature of all of the forms of paraphilia is that they are virtually the exclusive domain of males. Other than biological sex, there are few characteristics that distin-

guish individuals with and without paraphilia. All races and socioeconomic groups are represented among those with paraphilia, and the interest, if not the behavior, typically appears fairly early in development (sometimes in childhood, and usually by adolescence). The nature of the paraphilic fantasies and behaviors typically becomes more elaborate by late adolescence and early adulthood, and individuals commonly experience more than one form of paraphilia (e.g., Freund & Blanchard, 1986).

Another commonality among the various forms of paraphilia is that the individual experiences the sexual interests as ego syntonic, or something inherent in his or her being. In other words, individuals with paraphilia rarely experience their sexual fantasies or urges as distressing. Instead, the fantasies and urges feel natural. Of course, these individuals typically recognize that their sexual interests lie outside the norm and may go to great lengths to conceal them. Treatment seeking is generally precipitated by interpersonal or legal pressure, and the individual is more or less forced to undergo treatment because he or she has been caught. Also, the individual in treatment is likely to experience strongly conflicting feelings over the prospect of “losing” the paraphilia. On one hand, life would be easier and the threat of discovery or prosecution would abate. However, loss of the paraphilia equates to losing one’s sexuality and a tremendous source of motivation and pleasure.

Given the compelling nature of the sexual urges, **individuals with paraphilia may choose occupations or avocations to increase their access to the objects or people needed to carry out their paraphilia.** For example, an individual may choose to work in rental properties so as to have opportunities to “peep” on unsuspecting people who may be nude or engaged in sexual activity. Similarly, an individual with pedophilia may volunteer to work with Boy Scouts or at a summer camp to increase access to children of the preferred age. Even if the paraphilia involves consenting partners or inanimate objects, much time and energy might be spent locating potential partners or locating and viewing pornography that depicts the individual’s paraphilia.

Paraphilia involving nonhuman objects include fetishism and transvestic fetishism. Fetishism in general refers to the fixation on a nonliving object (such as a particular type of garment). According to the *DSM* (APA, 1994), the most common fetishes involve women’s undergarments and shoes. A man with the paraphilia may masturbate while rubbing or sniffing the fetish object, or he may require that his partner wear the object or in some way interact with it during sexual activity. Typically, the fetish object is necessary or preferred for sexual functioning. Absence of the object may result in lack of an erection or ejaculation. Accordingly, many male actors in pornographic films are presumed to have a fetish, which happens to aid in their occupational functioning. That is, having a fetish allows the actor to engage in vaginal or anal intercourse virtually indefinitely. When the director calls for the required

ejaculation, the actor mentally focuses on imagery associated with his particular fetish, thereby allowing him to become aroused enough to achieve orgasm (Faludi, 1995).

Virtually any object has the potential to serve as a fetish, and probably someone at some time has experienced just about every conceivable object as his or her fetish. Steele (1996, p. 26) lists some of the objects she encountered as fetishes in her investigation: hairbrushes, artificial limbs, safety pins, snails, cockroaches, whips, roses, eyeglasses, and the handlebars of an Italian racing bike. Still, some objects are much more likely to be a fetish than are others. For example, garments are overwhelmingly the most common type of fetish object (Steele, 1996). The individual may have a very specific garment that he or she experiences as a fetish, with a particular appearance or odor, or it may be the general texture of the garment that is most important. Such garment fetishes have been divided into two types: hard (leather, rubber) and soft (fluffy or frilly). The hard fetish items tend to be tight, constricting garments that are shiny and black, whereas the soft fetish items tend to consist of lingerie or furs.

If the fetish involves sexual arousal in response to actually wearing the traditional clothing of the other gender, the separate diagnosis of transvestic fetishism is used. Although theoretically both men and women, straight or gay, may experience transvestic fetishism, in practice only heterosexual males have been described as having this fetish (APA, 1994). The public and mass media often confuse the motivations of those individuals who may engage in cross-dressing. Individuals with problematic gender identity issues may cross-dress in an attempt to live (or "pass") as a member of the other gender, and hence the primary motivation is not sexual. In contrast, "drag queens" are typically gay men who dress as women for the attention, aesthetic appeal, and dramatic effect. Men experiencing transvestic fetishism tend to be traditionally masculine in their gender role identity and presentation, and many are involved in long-term heterosexual relationships. These men may engage in cross-dressing to various degrees and either consistently or only intermittently (e.g., during times of stress). Often the cross-dressing is accompanied by fantasy in which the individual imagines being both the male and female participants in sexual activity.

With regard to paraphilia based on humiliation or suffering of oneself or one's partner, the distinction is made between sexual sadism, or sexual arousal in response to the infliction of humiliation or pain on a partner, and sexual masochism, or sexual arousal in response to being the target of humiliation or pain from one's partner. Importantly, clinical diagnosis is reserved for those individuals whose paraphilic focus is on actual (rather than simulated) sadistic or masochistic activity (APA, 1994). Individuals who only role play sadomasochistic activities are not deemed to experience this form of paraphilia. The severity of the sadomasochistic acts needed to achieve sexual arousal may remain stable over years or a life-

time, but some individuals apparently need increasingly strong stimuli over time to achieve the same sexual result.

Certain masochistic acts may be self-inflicted, but usually sadomasochism involves finding a partner with similar interests. Accordingly, an elaborate sadomasochistic (S/M) subculture exists in the United States in which "bottoms" (masochists) look for "tops" (sadists). Also, S/M practitioners may have specific preferences regarding mode of humiliation or suffering. For example, he or she may find urinating on or being urinated on by a partner to be arousing, whereas another individual may focus on defecation. Other sadomasochistic activities include binding, gagging, blindfolding, spanking, whipping, choking, cutting, and piercing. Alternatively, an individual could be forced to cross-dress and/or beg for sexual access to one's own body or one's partner or could be treated like an animal or infant, all of which could be experienced as forms of subjugation or humiliation. Perhaps because of the diversity of activities included in the S/M subculture, practitioners are commonly tolerant of the preferences of other S/M devotees, even if they themselves do not find a particular activity appealing (Moser, 2001).

The remaining *DSM* classifications of paraphilia (exhibitionism, voyeurism, frotteurism, and pedophilia) share the fact that they involve nonconsenting victims. Exhibitionism (or "flashing" in common parlance) involves exposing one's genitals to an unsuspecting stranger. The individual might masturbate during the exposure or replay the incident in his head during a subsequent episode of masturbation. Common fantasies among exhibitionists are that the unsuspecting stranger will be shocked or will become sexually aroused and desirous of sexual activity with the exhibitionist (APA, 1994). Voyeurism (or peeping) is exhibitionism's complementary form of paraphilia with the exception that sexual arousal occurs in response to watching an unsuspecting person, usually a stranger, while the stranger is nude or engaged in sexual activity. Similar to exhibitionism, the voyeur might masturbate during the experience of voyeurism or mentally replay the experience during subsequent masturbation. The voyeur oftentimes fantasizes about engaging in sexual activity with the victim yet rarely experiences such activity (APA, 1994). A feature of both exhibitionism and voyeurism seems to be the unsuspecting nature of the victims. Engaging in or viewing nude dancing ("stripping") in a nightclub designed for that purpose does not offer the same thrill as engaging in the paraphilic activities surreptitiously.

Frotteurism involves rubbing one's genitals on an unsuspecting stranger or groping an unsuspecting victim's breasts, buttocks, or crotch. Frottage requires a physical setting in which the paraphilic individual has access to victims and can either perform the activity undetected or escape quickly once detected. So crowded subways, sidewalks, and other public events where people are packed together provide opportunities for frotteurism. Accordingly, this activity is virtually nonexistent in rural areas, and when it does exist, it may be played



out with victims who are sleeping or otherwise unaware of their surroundings. In terms of accomplishing the activity, the individual may wear a long overcoat or long baggy shirt so that his penis can be hidden yet easily accessible. Fantasies of a sexual relationship with the victim are common, although actual sexual activity with victims is rare (APA, 1994).

Pedophilia involves sexual interest in prepubescent children, usually age 13 years or younger. An individual may sexually molest a child yet not be generally attracted to sexual activity with children per se. This distinction makes research on pedophilia, and subsequent characterization of pedophiles, a difficult task. *DSM* diagnostic criteria include recurrent fantasies, urges, or behavior, yet the offending individual may deny pedophilic fantasies and urges and insist that the behavior was limited. Pedophiles are also known to exhibit denial, rationalize their behavior, and minimize its consequences (Cohen & Galynker, 2002). Given that legal penalties are heaviest for this form of paraphilia, there is the added incentive to deceive others regarding the true nature and extent of the paraphilia.

Some pedophiles are attracted exclusively to children, whereas others are also attracted to adults. As for the gender of victims, some pedophiles are exclusively attracted to girls, some exclusively to boys, and some to both boys and girls. Although the most common pattern is exclusive attraction to girls, those individuals attracted to boys report substantially larger numbers of different victims (Cohen & Galynker, 2002). Pedophiles also tend to each exhibit a preferred age range of victims (APA, 1994). All ages of victims have been represented among pedophiles, but most commonly those individuals attracted to girls prefer ages 8 to 10 years, and those attracted to boys tend to prefer a slightly older age range (APA, 1994).

Pedophilic interests typically first appear in late adolescence, sometimes making diagnosis and prosecution problematic during that developmental phase. Because childhood sexual play and curiosity is normative, each case needs to be evaluated in terms of the relative ages and maturity level of the alleged pedophile and alleged victim. A minimum age of 16 years for the pedophile and a perpetrator-victim age difference of at least 5 years has been offered as a guideline, although the *DSM* also notes that someone in "late adolescence" who is engaged in an ongoing sexual relationship with a 12- or 13-year-old should not be diagnosed as paraphilic (APA, 1994, p. 528).

The eight categories of atypical sexual behavior outlined above are all of those included in the *DSM*. What about sexual interest in animals (bestiality or zoophilia) or sexual interest in corpses (necrophilia)? These forms of paraphilia seem to capture the public imagination and have been the focus of numerous jokes. Each is rare, although apparently they do exist. For example, a recent review of bestiality and zoophilia included new data gathered from 82 men and 11 women who had had sexual contact with animals (Miletski, 2002). For

such paraphilic behavior not included specifically in the eight categories described in the *DSM*, there is the diagnosis of "paraphilia not otherwise specified" (APA, 1994). The *DSM* lists as examples of this category zoophilia, necrophilia, telephone **scatologia** (obscene telephone calls), **partialism** (exclusive sexual focus on a body part, such as the feet), **urophilia** (urine), **coprophilia** (feces), and **klismaphilia** (enemas). Most recently, paraphilic-like behavior of clinical interest and discussion includes the compulsive use of the Internet to access pornography, perform sexually explicit chat, or secure potential sex partners (Cooper, 2002).

## MODELS OF ETIOLOGY

What causes or leads to paraphilia? If you can definitively answer that question, your working days are over. Several models have been offered, but the lack of empirical data results in **questions as to the accuracy of each theory** (Wincze, 2000). To complicate the picture, some theories are meant to apply only to particular forms of paraphilia or to particular subgroups within one category of paraphilia. The existing explanations for paraphilia tend to fall into the more general categories of biological explanations, psychoanalytic explanations, and cognitive-behavioral or conditioning explanations.

**Biological** explanations have included the notion that perhaps **paraphilia is related to hormones**. However, research has failed to show relationships between circulating hormonal levels and atypical sexual fantasies, urges, or behaviors (Krueger & Kaplan, 2002). Relatively increased levels of androgens (testosterone) are related to more frequent sexual fantasies and urges, but that is true regardless of the gender of the individual or the focus of his or her sexual desires. In other words, testosterone is related to the quantity but not the quality of sexual interest. Instead of focusing on hormonal levels, more recent biological explanations involve altered brain functioning in individuals with paraphilia, perhaps as a result of early developmental trauma (Cohen & Galynker, 2002). Such research is still in its infancy.

**Psychoanalytic explanations** date back to Freud and were **focused primarily on development of fetishes**. Initially, these explanations relied on the notion of castration anxiety aroused when a young boy first discovered that his mother did not have a penis (and therefore the young boy has the potential to lose his). The fetish object is seen as an unconscious substitute for the mother's "lost" penis (Steele, 1996). By fixating on the fetish object and perhaps requiring that sexual partners wear or associate themselves with the object, the individual with the fetish gets to maintain the unconscious fantasy that his female partner has a penis, thereby not rousing his unconscious castration anxiety. Why the particular fetish object chosen by the individual? The theory is that it relates to the last moment before the boy learned of his mother's castrated state. So, women's undergarments or women's shoes might be the last object noticed at that crystallizing moment when

the boy saw his mother's genitals. Similarly, a fur fetish might be based on the symbolism between fur and pubic hair, or a silk stocking fetish symbolically represents the mother's shaved legs. Typically the moment of realization that mother does not have a penis happens early enough in the boy's development that, as an adult, he is unable to recall the experience and the accompanying details.

More contemporary explanations of paraphilia in the psychoanalytic vein have focused more on object relations and possible problematic childhood attachment as a developmental precursor to paraphilia (e.g., McCormack, Hudson, & Ward, 2002). The popular assumption that someone with paraphilia experienced childhood sexual abuse or trauma is based on an object relations perspective (a developmental outgrowth of psychoanalytic thought). In essence, the explanation is that such abuse in early relationships with caregivers manifests itself as subsequent problems in the ability to establish and maintain healthy, intimate relationships. Instead, the individual seeks to satisfy sexual urges through nonrelational means (e.g., by reliance on a fetish object), pseudorelationships (e.g., exhibitionism, voyeurism, or frotteurism), or relationships with partners that are based on disproportionate power (e.g., S/M).

Cognitive-behavioral and learning explanations also emphasize early sexual experiences, but the emphasis is on subsequent thoughts and behaviors and their consequences. For example, a classical conditioning explanation of paraphilia is based on the simple principle that whatever stimuli were present during initial sexual experiences (typically sexual arousal accompanied or followed by masturbation) become paired with the sexual arousal and orgasm. Therefore, an individual who, typically during childhood or adolescence, happens to look into someone's open window and witness nudity or sexuality activity may become sexually aroused. If the individual continues to look and begins to masturbate or replays the experience in his mind later while masturbating, the experience of voyeurism has now been associated with sexual arousal and pleasure. The experience of orgasm reinforces the voyeuristic behavior or fantasy, making reliance on the voyeurism more likely in the future (operant conditioning). Each time the individual returns to voyeuristic behavior or imagery during episodes of sexual arousal and orgasm, the association is strengthened (classical conditioning).

The behavioral explanation of paraphilia does beg the question why some individuals with a particular early sexual experience elaborate that experience into a paraphilic interest, whereas others do not. Part of the answer may lie in biological predispositions toward being more motivated by sexual risk taking versus inhibition (Janssen, Vorst, Finn, & Bancroft, 2002) or to experiencing the initial sexual experiences during certain critical developmental windows (Wincze, 2000). Another part of the answer may lie in whether that initial sexual experience was evaluated as posi-

tive or negative by the individual. To return to the voyeurism example, if the boy had noticed the nudity or sexual activity and experienced embarrassment, he may have been motivated to look away and not think of the incident again. Perhaps this combination of factors explains why males are so much more likely than females to develop paraphilia. Relative to girls, boys have few proscriptions regarding sexuality, and having a penis and erections rather than a vagina and lubrication allows boys to be more aware of their sexual arousal.

The classical conditioning explanation for the origination of paraphilia seems to be the most widely accepted (Hall, 2000). It seems to offer a plausible explanation that frequently fits with the experience of individuals with paraphilia, most of whom can recall an early experience or series of experiences that seemed to spawn the current association to sex (Kaplan, 1991). However, it is probably not sufficient to explain the elaborate evolution of some forms of paraphilia over the course of the individual's lifetime or the intense motivational state that often accompanies paraphilia. Recently, authors have proposed that a classic cognitive phenomenon, the Zeigarnik effect, may help explain the ongoing motivation underlying paraphilia (Munroe & Gauvain, 2001). The Zeigarnik effect refers to our tendency to remember and ruminate over interrupted tasks to a greater degree than completed tasks. In other words, thwarted goals produce a psychological tension that motivates the individual to return, at least mentally, to the unmet goal.

As applied to paraphilia, being raised in a sexualized environment (which may be said to characterize contemporary Western cultures) provides numerous opportunities to experience titillation and sexual arousal without satisfaction. An unmet need or goal results in attempts to return to the task to obtain satisfaction. Assuming continued frustration, as the individual matures, the experiences of thwarted sexual arousal remain in the past, where they cannot be completed, thus becoming a part of the person's permanent repertoire (Munroe & Gauvain, 2001). This explanation fits with the observation that paraphilia as we currently conceive of it appears to be exclusively a Western phenomena that seems to have originated in the 19th century, as contemporary Western culture may be unique in its abundance of sexually explicit stimuli combined with widespread prohibitions about deviant sexual behavior (Munroe & Gauvain, 2001; Steele, 1996). This explanation might also at least partially explain the male-female difference in the likelihood of paraphilia. Most sexual stimuli in Western culture are aimed at a male audience, and having a penis may make it more noticeable when one is sexually aroused but not satisfied.

As is apparent, the existing theories to explain the development and continuation of paraphilia are speculative and in need of additional elaboration and empirical data. Unfortunately, the lack of powerful explanatory models does not relieve clinicians from the need for effective treatments for those individuals who are distressed by their paraphilia or

whose paraphilia is harmful to others. This review concludes with a brief introduction to the predominant treatments for paraphilia.

### TREATMENT OF PARAPHILIA

Just as the primary models for explaining paraphilia fall into psychoanalytic, biological, and cognitive-behavioral domains, so do the proposed treatments. In brief, psychoanalytic approaches involved discovering the developmental/intrapsychic source and working through those underlying conflicts or unresolved issues. Biological approaches involve suppressing sexual drive and decreasing compulsivity. Cognitive-behavioral approaches involve breaking the association between unacceptable stimuli and sexual arousal, reinforcing more appropriate sexual stimuli, and relapse prevention. The most common treatment regimen combines biological and cognitive-behavioral interventions and will be described in more detail.

In general, androgens increase sexual interest, whereas estrogens and estrogenlike compounds suppress sexual desire. Sexual offenders are commonly administered antiandrogenic substances for just such a purpose (Gijs & Gooren, 1996; Rosler & Witztum, 2000). For example, Depo Provera has been commonly used because it reduces sexual drive in men and is administered by a health care professional rather than by the patient (Wincze, 2000). Although effective, treatment compliance has been a problematic issue due to side effects. More recently, gonadotropin-releasing hormone agonists have been used with promising results (Krueger & Kaplan, 2002). These substances can be administered in depot formulations and exhibit fewer side-effects than traditional antiandrogenic drugs. The use of serotonin reuptake inhibitors (SRIs) has also shown promise (Rosler & Witztum, 2000). At this point, it is unclear whether SRIs are effective due to the effects on decreasing compulsivity associated with the paraphilia or due to the common side-effect of reduced sexual interest (Cohen & Galynker, 2002). These drugs are only available in self-administered forms, but they typically result in higher patient compliance than the antiandrogenic substances because of the lower rates of side-effects (Krueger & Kaplan, 2002). The SRIs have the added advantage of treating depression and anxiety that may also be part of the clinical picture in many cases.

Behaviorally, the task of treatment is to "unlearn" the association between the inappropriate stimulus and sexual arousal. Typically, that inappropriate association has been strengthened over a substantial period of time and a large number of instances. The opposite of sexual arousal is either lack of arousal or an aversive experience. If treatment involves pairing the stimulus with lack of arousal, the term *satiation* is used. Typically, the individual is instructed to masturbate to the preferred stimulus or fantasy images, then to continue to do so for a prescribed period of time after

orgasm. After orgasm, the paraphilic interest and the additional physical stimulation will hardly hold the attraction they did prior to orgasm. The idea is that the stimulus will eventually be paired with boredom and/or annoying stimulation.

If the treatment involves pairing the inappropriate stimulus with an aversive experience, the terms *covert sensitization* or *aversion training* are used. Covert sensitization involves mentally pairing the preferred stimulus with negative imagery. For example, when a man fantasizes about women in high-heeled shoes walking on his chest and becomes aware that he is beginning to have such fantasies, he is to switch to aversive imagery, such as the woman vomiting first, followed by his vomiting. Aversion training involves the more direct association of the inappropriate stimulus and an actual negative experience, such as electric shock or an aversive odor. The individual is instructed to begin to fantasize about the preferred stimulus, and then is either administered a shock or exposed to a noxious odor. The hope is that eventually the inappropriate stimulus will fail to be sexually arousing as the individual attains a negative association to the stimulus. Aversion training has been shown to be effective in at least some cases, but its use is controversial because of the infliction of pain or noxious stimuli (Krueger & Kaplan, 2002).

Other components of the cognitive-behavioral treatment of paraphilia involve behavioral monitoring by significant others in the individual's life and maintaining a daily log to record instances of particularly strong sexual urges so that precursors or triggers can be identified. Cognitively, thought stopping may be of some use. When the individual is aware of a thought about the inappropriate stimulus or behavior, he or she shouts "Stop!" either in actuality or internally, thereby interrupting the problematic thought. With paraphilia involving nonconsenting partners, cognitive work might entail victim empathy and critical examination of the distorted perceptions and beliefs the individual likely holds. That is, sexual offenders often hold distorted perceptions as to the desires of their victims, the effects of the offender's behavior on his victims, and so forth (Cohen & Galynker, 2002).

On the more positive side, cognitive-behavioral treatments may include building skills to establish and maintain appropriate sexual relationships. These interventions are based on the observation that individuals with forms of paraphilia that involve nonconsenting partners often demonstrate deficits in the normative courtship process (Freund & Blanchard, 1986). Such interventions include addressing possible sexual dysfunction and ignorance as well as working on social skills, communication, and assertiveness (Krueger & Kaplan, 2002). The overall goal is to improve the ability to engage in mature relationships with consenting adult partners, thereby decreasing the need to rely on paraphilic behavior for sexual arousal and satisfaction.

As improvement occurs, the focus of intervention may shift to include relapse prevention as employed in the treatment of other disorders such as substance abuse and eating



disorders. Specifically, the individual is guided to (a) identify, anticipate, and avoid high-risk situations; (b) identify behavioral chains that lead up to the problematic behavior; and (c) anticipate strategies to intervene and disrupt the behavioral chain at various points.

### IN CLOSING

Paraphilia and fetishism represent a class of disorders that is both intriguing and controversial yet socially important. Whenever sexuality is involved, issues of value judgment and what is acceptable versus unacceptable come into play. It is important to remember that diagnosis of a clinical problem in this area must include the criterion that the sexual fantasies, urges, or behaviors cause the individual distress or involve nonconsenting partners. Even still, assessment may be difficult due to the secretive nature of the relevant experiences and the reliance on self-report of symptoms. Typically, the individual with paraphilia will be reluctant to give up his preferred sexual outlets, so treatment is likely to occur under duress, legal or otherwise. Other than biological interventions, treatment relies on the cooperation of the paraphilic individual. All of these issues and others make the assessment, diagnosis, and treatment of paraphilia challenging for the clinician.

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