

Spring 2018

# Seminar in paraphilic disorders

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Seminar in Paraphilic Disorders

Kim Elise Hall

A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Educational Specialist

Clinical Mental Health Counseling

May 2018

FACULTY COMMITTEE:

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## **Acknowledgments**

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## **Abstract**

This project provides curriculum materials for a graduate level seminar in paraphilic disorders as an Ed.S. research project. The rationale for developing such a curriculum is introduced and a review of supporting literature is included, detailing the definition, prevalence, and controversy surrounding paraphilic disorders. Literature regarding counselor education in paraphilic disorders and evidence for a gap in current counselor education in paraphilias are reviewed. The curriculum materials designed to meet this need are presented and discussed, as are the benefits and limitations of this curriculum.

## **Background**

Counselor education by necessity includes some discussion of human sexual behavior. Counseling students learn about sexual connection and dysfunction when they review couple and family systems, look at paraphilic disorders when learning psychopathology, and examine attraction and transference studying counseling process. For the majority of their client populations, counselors do not require more than this background knowledge and their empathic capabilities. But for a small population, counseling practitioners need to be prepared for a greater challenge to their empathy, and need to be prepared with more information. Individuals with paraphilic disorders rarely self-refer for counseling for a number of reasons, but clinicians must to be prepared for them when they do present.

Paraphilias are complex aspects of sexuality that can be deeply troubling for clients and clinicians alike. Individuals who endorse sexual interest in practices counselors may view as disgusting, immoral, dangerous, illegal, or evil are a huge challenge to our ability to empathize. Clients could present with a tremendous variety of potential paraphilic behaviors. Further education in paraphilias for master's-level counseling students is appropriate and necessary, not only to provide care for those individuals who have paraphilic disorders, but also to practice counseling skills at empathizing with controversial and difficult subjects, and to gain a fuller understanding of the spectrum of human sexual behavior.

Currently, literature on educating counselors about paraphilias appears to be lacking. There is no substantial review or assessment of counselor education programs that focus on paraphilias or sexuality. This near if not total absence of literature prompts the need for more research and discourse on the topic within the field of counseling and counselor education. I believe that one of the most effective ways to counter this apparent lack of research is to not only

summarize and review what research is available, but to design a sample curriculum to fill the gap in current counselor education. The curriculum materials presented in the appendices have been developed to meet this current need.

### **Review of Literature**

Paraphilias are sexual feelings and interests in a client that differ from the average sexual feelings of a client's general population. The DSM-5 defines two criteria for the diagnosis of paraphilic disorder: the client must feel significant personal distress or experience significantly impaired functioning about their particular sexual interest; or the client must have a sexual desire or behavior that compromises another person's well being, either physical or psychological (American Psychiatric Association, 2013). The prevalence of paraphilias and paraphilic disorders is difficult to determine, as many people with paraphilic disorders do not seek treatment, because of social stigma surrounding their practices, because of legal ramifications, or because the pleasure of their activities outweighs any negative effects. It is known that males are more likely than females to be diagnosed with a paraphilic disorder and display paraphilic interests in general. There seem to be no predictive ethnic or socioeconomic factors in diagnosing paraphilic disorders, but psychological comorbidities are often present (Seligman & Hardenburg, 2000).

The categorization and treatment of paraphilic disorders remain controversial, both in academic and clinical settings, and among the general population. Balon pointed out that "...the border between *normal* or acceptable sexual behavior and *abnormal* sexual behavior is fuzzy [emphasis in original]" (2013, p. 10). Keenan (2013), who identifies as a member of the kink community (individuals who engage in paraphilic sexual behavior for pleasure), maintained that keeping paraphilic disorders in the DSM-5 is "redundant, unscientific, and unnecessary, and harmful" (para. 14). She recommended that the approach to treating someone with distress over

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the paraphilia should be to ease the distress and not pathologize the sexual desire by attaching a diagnosis to it, especially since being diagnosed with a DSM disorder can have serious social and legal consequences (Keenan, 2013). Most treatment planning has been developed and studied in the treatment of sex offenders, who may or may not have actual paraphilic disorders, such as exhibitionistic disorder or frotteuristic disorder. These forensically-oriented therapeutic approaches are generalized to clients with other, non-criminal presentations of paraphilic disorders, as the study of these has historically been limited. Most reported treatments of non-criminal paraphilic disorders follow the approaches taken to address sex offender-related paraphilic disorders (Marshall & Marshall, 2015).

Literature specifically regarding educating professional counselors in paraphilias and paraphilic disorders appears to be sparse. An internet survey of 162 clinical and counseling psychologists indicated that their graduate training included elements of sexuality, but was not standardized in terms of content or depth. Sexuality education trended towards sexual problems such as violence and pathology, as opposed to healthy sexual practices. The content of individuals' training programs was found to be more predictive of eventual knowledge of sexuality than individuals' characteristics, such as religious background (Miller & Byers, 2010). This study could possibly be extrapolated to graduate programs for professional counselors, in that the content of the training program plays the greatest role in the trainees' eventual knowledge of sexuality.

Attitudes and beliefs about paraphilias in the counseling population are likewise not well described in the literature. There is some literature regarding counselors' and counselor educators' attitudes towards different sexual orientations that could be extrapolated to attitudes towards paraphilias. A survey of 154 counselor educators concluded that while overall bias rates

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were low, there was higher bias exhibited surrounding different sexual orientations than surrounding racial identities. Heterosexism (bias toward heterosexuality) scored higher than other domains of bias (Miller, Miller, & Stull, 2007). While sexual orientation should not be conflated with paraphilia, it is worth considering that some constructs may both encourage heterosexism and stigmatize atypical sexual behavior, and that these constructs may be found in counselor education. These constructs may include a predominantly heterosexual and normophilic sample of clients, or a model of multicultural counseling that focuses on variables other than sexual identity or preference. There may also be a generational difference in the bias of counselor educators versus beginning counselors on average.

Students may also enter graduate-level counseling study with biases. A study of 178 United Kingdom undergraduates in both psychology and non-psychology training programs found that psychology students had more negative attitudes towards hypothetical sex offenders than non-psychology students (though both groups were less negative than the general population of non-students) (Harper, 2012). Those training in child-related studies exhibited the most negative views towards sex offenders. The study author suggested that this negative attitude is perpetuated by course material focused on safeguarding children, and may result in higher false-positives when evaluating children at risk (2012). Two possibilities may be hypothesized for counseling graduate students from this study. One, students may enter a graduate counseling degree program with biases surrounding atypical sexual behavior, such as that seen in sex offenders. Two, course content that is focused extensively or exclusively on managing risk to potential victims of sex offenders may bias students against those exhibiting paraphilias or paraphilic disorders.

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Without a large body of literature to draw upon, it is still reasonable to guess that the attitudes and knowledge of paraphilias in counseling students are largely influenced by the content and quality of their educational programs. I have not been able to identify any studies on best practices for teaching counseling students about paraphilias or any assessments designed to measure counselor knowledge of paraphilias. This constitutes evidence for a gap in the literature surrounding the education of counselors in atypical sexual behavior. This is not surprising; paraphilias and paraphilic disorders are rare, and self-identification of paraphilias in counseling is rarer. Additionally, the paramount considerations in treatment of paraphilic disorders are often managing risk and legal concerns in the case of sex offenders, as opposed to providing treatment for individuals who are not offenders. However, these concerns should not preclude the study of paraphilias in counseling. The American Association of Sexuality Educators, Counselors, and Therapists (AASECT, 2013) supports clinical intervention and care for all individuals regardless of sexual preference:

AASECT recognizes the prevalence of sexual practices that are unhealthy, and unhappy, and acknowledges that many people struggle with sexual distress, disorder, and dysfunction. AASECT believes that there is an urgent need for sexual healing practices that is, for biopsychosocial or holistic care, for therapeutic intervention, and for personal growth opportunities to be made available to all people, who are compromised in their pursuit of sexual health and happiness. AASECT further believes that opportunities for sexual healing should be accessible to every individual interested in furthering their capacity for erotic pleasure as well as for gratifying emotional relationships, and that such services should be provided in a manner that secures the client's or patient's privacy, confidentiality, and self-respect. (AASECT)

Furthermore, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) identifies the following as an entry-level standard for counseling practice:

“human sexuality and its effect on couple and family functioning” (CACREP, 2014).

Understanding paraphilias is an essential element of meeting both AASECT and CACREP

standards of practice. Beyond that, understanding paraphilias is essential to the learning process of building empathy for unique and challenging populations. The fullness of human experience is not captured without a beginning understanding of the variety of human sexual experience.

The development of this curriculum has been based on these gaps identified in counselor knowledge and education on paraphilic disorders. The curriculum materials include five lesson plans (for a once-weekly, five week one-credit seminar), slides, a syllabus, assignments, and a list of suggested reading materials. Resources for survivors of sexual abuse or assault are also included.

### **Discussion**

This project is conceptualized as a ready-made curriculum for teaching master's-level counseling students about paraphilias and paraphilic disorders, combined with a rationale for the development of such a curriculum. My intention is to increase the ease of access to these educational materials for counselor educators. With a readily accessed curriculum, educators may feel more prepared to offer the additional training and evaluation required for beginning counselors to have a more comprehensive understanding of paraphilic behavior. I feel strongly that a fully-developed curriculum thus has a greater impact on the counseling field than a researched recommendation for the development of such a curriculum. Given the difficulty I had in finding literature on teaching counselors about paraphilias, the conclusion that we need more education is easily drawn. A wholly developed class meets that educational need in a way that simply naming the need cannot accomplish.

The curriculum is intended to highlight the ethical considerations surrounding treating atypical sexual behavior. Questions about client-counselor confidentiality, risk, legality, and multicultural awareness are explored throughout the curriculum. The course content is based

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around the paraphilic disorders included in the DSM-5, as well as the non-disordered variants of paraphilic sexual behavior described alongside them. Treatment planning and case studies are a key component of the course. I especially want to draw students' attention to potential areas of countertransference, such as unexpected feelings of attraction and arousal at novel sexual presentations, or feelings of being re-traumatized by clients.

One question I had while developing this curriculum was whether to include some kind of "trigger warnings" within the course material. Some of the atypical sexual behavior the course covers includes such disorders as pedophilia and sexual coercion. It is both plausible and probable that there will be students of counseling- or counselor educators- who are dealing with the traumatic effects of sexual assault, abuse, or molestation. I wanted to develop the curriculum in a way that would be sensitive to the needs of these students and educators, while at the same time not shying away from material vital to conceptualizing and building empathy for individuals with such disorders as pedophilic disorder. I decided on putting a "content consideration" in the syllabus detailing the expectations for students participating in the course, effectively making the syllabus an informed consent to participate in discussion of these sensitive issues.

I truly believe that despite the relative paucity of background literature, making this course truly comprehensive would involve writing several books and offering an entire degree of study, rather than one class. The spectrum of human sexual behavior has so much variance that I think it is impossible to deliver a truly comprehensive set of five lectures on the subject. Since I narrowed my focus to the paraphilic disorders outlined by the DSM-5 and their non-disordered counterparts, I think that this curriculum trades a broad survey approach to sexuality for an approach with greater diagnostic utility. As the DSM-5 is the most accessible diagnostic aid and

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psychopathology handbook available to clinicians, I think using it as a prompt for further exploration and conceptualization makes sense for this educational setting.

The course content closely follows describing the clinical presentation of paraphilic disorders, the diagnostic process, and conceptualization and treatment planning. As it is currently written, the course does not include substantial experiential elements, such as practicing counseling interventions through role play. I chose to limit the course in this way for two reasons. First, this brief seminar is intended to build fundamental knowledge of paraphilic disorders, to a level of competency not achievable by a half-lecture in a psychopathology survey course. While many other mental disorders are frequently encountered in other counseling classes and in clinical site training (depression, anxiety, mood disorders, psychotic disorders, and personality disorders spring to mind), paraphilic disorders present so rarely that it seems unlikely a beginning clinician would receive this kind of exposure. Substantial knowledge of the diagnosis of paraphilic disorders, developed well before encountering a client, will increase the ability of the clinician to begin planning treatment. It will also maximize the benefit of any supervision they receive, as supervision can then focus on interventions and managing clinician reactions, instead of on the basics of the disorder presentation. Second, the sensitive and complex nature of paraphilic disorders does not always lend itself well to roleplay situations. While some disorder presentations are characterized solely by client distress, others are potentially contingent on victimizing or intending to victimize a non-consenting person. There is a difference between conceptualizing and empathizing with clients who commit acts we find abhorrent, and actually pretending to personify those clients with our bodies and our words, and I want to acknowledge and honor that distinction. This is especially important for beginning clinicians, who are still

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learning to integrate their personal and professional identities in an appropriate and self-compassionate way.

Despite my limited inclusion of experiential work, the course is structured such that instructors do have the option of adding experiential activities as they see fit. It is worth noting that much of the recommended treatment for paraphilic disorders mirrors interventions counseling students learn in other courses and field work, such as crisis evaluation and risk management, cognitive-behavioral interventions, person-centered approaches, psychoeducation, and anxiety management techniques. Instructors may wish to have students demonstrate the integration of these interventions in the setting of a paraphilic disorder, rather than attempt to teach new intervention techniques from scratch.

An ambitious future direction for this research project would be to offer the seminar to actual graduate students and assess their understanding of the material before and after completing the course. Without actually implementing this course, my assumptions about the benefits it would provide clinicians and their clients remain assumptions. Measuring the outcomes of providing this course to counselors and counselor educators would provide information on whether this curriculum does in fact fill the gaps in counselor knowledge. This curriculum could also be edited and tailored to a variety of educational settings beyond the graduate classroom, including inservice programs for community clinicians and broadly distributed CEUs for professionals of many backgrounds. In making these materials widely available, my hope is that they will provide beginning and seasoned clinicians increased knowledge, insight, and empathy toward this rare, challenging, and fascinating population of clients.

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## Appendix A. Syllabus

### Seminar in Paraphilias

James Madison University Department of Graduate Psychology

M 11:45am-2:15pm

Fall 2018

Kim Hall

hall7ke@dukes.jmu.edu

540-746-3005

Office hours M 9:00am-11:30am and by appointment

#### *Course Description*

This course is intended to give an introduction to paraphilic disorders as defined by the DSM-5 and present an overview of presentations, treatment options and planning, and considerations for counselors. Considerable attention will be given to examining counselor attitudes and biases surrounding paraphilic disorders and paraphilias in general. This course is a discussion-based seminar that includes readings, reflections, and case conceptualization. The curriculum is intended to highlight the ethical considerations surrounding treating atypical sexual behavior. Questions about client-counselor confidentiality, risk, legality, advocacy, and multicultural awareness will be explored throughout the curriculum.

Content consideration: This course covers topics including sexual abuse, sexual trauma, and non-consensual sexual activity in an in-depth fashion. Students will be expected to participate in class discussions of these topics. The instructor will make every effort to ensure class discussions take place in a safe, empathic, and confidential environment. Students are welcome to bring any concerns to the instructor, and a list of resources for survivors is included at the end of this syllabus.

#### *Course Goals*

Students who complete this course successfully will be able to:

- Describe the paraphilic disorder diagnostic criteria as presented in the DSM-5
- Give an overview of different treatment options for different paraphilic disorders
- Address different ethical and legal concerns in treating paraphilic disorders
- Conceptualize and treatment plan for clients with paraphilic disorders

#### *Required Texts, Materials, or Equipment*

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Other readings will be provided

***Course expectations***

Students are expected to read the assigned readings prior to the start of class and arrive prepared to discuss their interpretations with others. Attendance is mandatory; more than one unexcused absence will affect the class participation grade. Please talk with me if you need to miss class and we will consider your options for covering the missed materials.

***Major Assignments***

**Reflections:** There will be three reflections due prior to the week 2, 3, and 4 classes. These reflections will be based on your reading or research for the upcoming lecture; your class discussion, readings, and thoughts from the prior lecture; and/or questions, thoughts, or feelings you may have from the course in general. Reflections should be 1-2 pages in length and follow APA format, and both hard and electronic copies are acceptable.

**Case conceptualization:** Each student will present a case conceptualization on a client with a paraphilic disorder of their choice. Students will select a case presentation developed either by the course instructor or by the DSM Library collection of case presentations. As the presentations are fictionalized, students will be graded on their arguments for their selected diagnosis/diagnoses, the appropriateness of their developed treatment plan for their chosen diagnoses, and their discussion of relevant ethical, legal, multicultural, and personal considerations in developing and implementing that treatment plan. The case presentations will be selected during week 4 and presented for class discussion during the final week (there will be a two week break between week 4 and the final class to accommodate this). Conceptualizations should be around 5-7 pages and include citations for any resources used.

**Class Participation:** As a seminar based in class discussion, it is essential that you are prepared to talk about your thoughts, feelings, observations, and research in this class. Student engagement will be observed and graded for consistency, content, quality, and collegiality. Class discussions are confidential, and the disclosures of others are not to be discussed outside of the classroom setting.

***Course Grading***

Students will be graded on a numerical grading scale based on the satisfactory completion of their assignments and participation in class discussions.

Reflections: **3 x 10 points each = 30 points**

Class participation: **30 points**

Case conceptualization **40 points for a total of 100 points**

≥90 points = A

80-89 points = B

≤70 points = Unsatisfactory

***Course Policies and Information for Students***

***Academic Honesty***

Making references to the work of others strengthens your own work by granting you greater authority and by showing that you are part of a discussion located within an intellectual community. When you make references to the ideas of others, it is essential to provide proper attribution and citation. Failing to do so is considered academically dishonest, as is copying or paraphrasing someone else's work. The consequences of such behavior will lead to consequences ranging from failure on an assignment to failure in the course to dismissal from the university. Because the disciplines of the Humanities value collaborative work, you will be encouraged to share ideas and to include the ideas of others in our papers. Please ask if you are in doubt about the use of a citation. Honest mistakes can always be corrected or prevented.

The JMU Honor Code is available from the Honor Council Web site:

<http://www.jmu.edu/honor/code.shtml>.

***Disability Accommodations***

If you need an accommodation based on the impact of a disability, you should contact the Office of Disability Services (Wilson Hall, Room 107, [www.jmu.edu/ods](http://www.jmu.edu/ods), 540-568-6705) if you have not previously done so. Disability Services will provide you with an Access Plan Letter that will verify your need for services and make recommendations for accommodations to be used in the classroom. Once you have presented me with this letter, you and I will sit down and review the course requirements, your disability characteristics, and your requested accommodations to develop an individualized plan, appropriate for this seminar.

***Inclement Weather***

JMU's full inclement weather policy can be viewed here:

<http://www.jmu.edu/JMUpolicy/1309.shtml>. If class is cancelled due to inclement weather, a make-up time will be decided upon by the instructor and students.

***Religious Observation Accommodations***

All faculty are required to give reasonable and appropriate accommodations to students requesting them on grounds of religious observation. The faculty member determines what accommodations are appropriate for his/her course. Students should notify the faculty by no later than the end of the Drop-Add period the first week of the semester of potential scheduled absences and determine with the instructor if mutually acceptable alternative methods exist for completing the missed classroom time, lab or activity.

***Add/Drop***

JMU's add/drop schedule is available [here](#).

***Disclaimer***

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The instructor reserves the right to make modifications to this information and schedule throughout the semester.

*Schedule of Topics, Readings, and Assignments*

Date	Topics/Assigned Readings/Homework	Due
Week 1	Introduction to paraphilic disorders Before class: read syllabus, pp. 685-686 in DSM-5, <a href="#">Paraphilic Disorders</a> , <a href="#">Balon, R.</a>	
Week 2	Exhibitionistic, Frotteuristic, and Voyeuristic Disorders Before class: finish reflection 1, read pp. 686-694 in DSM-5, <a href="#">Wakefield, J.C.</a> , <a href="#">Ross, C.A.</a> , <a href="#">DeFeo, J.</a>	<b>Reflection 1</b>
Week 3	Sexual Sadism Disorder, Sexual Masochism Disorder, Pedophilic Disorder Before class: finish reflection 2, read pp. 694-700 in DSM-5, <a href="#">Keenan, J.</a> , <a href="#">Malone, L.</a> (this piece contains some graphic descriptions of child sexual abuse)	<b>Reflection 2</b>
Week 4	Fetishistic Disorder, Transvestic Disorder, Other Specified and Unspecified Paraphilic Disorder Before class: finish reflection 3, read pp. 700-205 in DSM-5, <a href="#">Joyal, C.C.</a> , <a href="#">Bhugra, D. et al.</a>	<b>Reflection 3</b>
Final Week	Case conceptualizations Before class: Select one of the included case presentations; develop and finish case conceptualization and arrive prepared to discuss your materials	<b>Case conceptualization</b>

**Questions for discussion, reflection, and conceptualization**

These are questions you may wish to consider while writing your reflections and case conceptualization, as well as while participating in class discussions.

**1. Primary concerns**

First, can I find out if anyone is in danger?

Has anyone already been harmed?

Do I know how to report this harm or risk of harm?

Do I know when it's appropriate to report this?

**2. Definitions**

How do I understand the meaning of paraphilia? Of paraphilic disorder?

Do I agree with the DSM-5 definition?

If not, how else can I conceptualize my client? For myself? For insurance purposes?

**3. Sexuality**

What is normal sexuality to me?

What is abnormal sexuality to me?

How do I react to descriptions of abnormal sexuality?

How do I handle my repulsion, if I have it?

What other feelings arise? Curiosity, arousal, anger, anxiety, something else? How do I understand these feelings?

**4. Preconceived ideas**

What am I expecting a client with a paraphilic disorder to be like?

Do I know why?

How would I feel when presented with a counterexample?

**5. Knowledge**

Where are the gaps in my knowledge of paraphilias? Of paraphilic disorders?

Do I know where I can seek out this knowledge? Am I comfortable looking for it?

**6. Big questions**

What's the difference between dangerous and illegal?

Illegal and immoral?

Immoral and dangerous?

Dangerous and abnormal?

Immoral and abnormal?

Illegal and abnormal?

What're my ethical obligations in the face of all these questions?

## Case Presentations

Select one of the following case presentations for your final case conceptualization project. Make sure to include your diagnosis, which may or may not be a paraphilic disorder. Include your justification for your selected diagnosis, your considerations of relevant ethical, legal, and cultural factors, and your prospective treatment approach. Each case includes a diagnosis and discussion written by the authors, which will be revealed and discussed in class after the conceptualizations are presented.

Case sources: Federoff, J.P., Balon, R., Needell, N.J., & Barnhill, J.W. Paraphilic Disorders. In Barnhill, J.W. (ed) (2014), *DSM-5™ Clinical Cases*. Arlington, VA: American Psychiatric Association.

**Case 1.** Raven Lundquist arrived half an hour late for her psychiatric evaluation. A 24-year-old graduate student in philosophy, she was dressed in black, appeared sullen, and avoided eye contact. She had recently moved home to live with her parents.

With some encouragement, Ms. Lundquist explained that the appointment was her mother's idea. Until 2 weeks earlier, Ms. Lundquist had been living in a lesbian relationship with Sandy Morrison. The relationship collapsed when Ms. Morrison caught Ms. Lundquist kissing her (Ms. Morrison's) brother. Furious, she sent the diary kept by Ms. Lundquist to the latter's mother, after first writing "SADIST" across the cover. The diary was filled with explicit descriptions of bondage, control, and whipping. Much of it involved Ms. Lundquist's feelings when she disciplined Ms. Morrison, but other entries discussed "BDSM [bondage, domination/discipline, sadism/submission, and masochism] sex parties" in which Ms. Lundquist appeared to enjoy being paid to inflict pain and humiliation on older men.

Ms. Lundquist said the consultation was "absurd. There's no problem, except that if I don't get psychiatric 'help,' I'll be kicked out to the curb. I'm a top [dominant sexual partner]. So what?" Ms. Lundquist agreed to return for a second session with the understanding that the psychiatrist would "hear my side of the story and decide whether therapy would be a good idea."

At the second session, Ms. Lundquist said she decided to study philosophy after reading *Justine* by the Marquis de Sade. "It's not as good as *Lolita*, but it struck a chord." She said she intended to specialize in the ethics of medical treatments. "Yeah, there's a control issue there, but I also like the idea that individuals have rights. I never tied anyone up who didn't ask for it." Ms. Lundquist admitted to drinking more than she should, often drinking to intoxication when she meant to only have a drink or two. Most of her fights with her mother and with her girlfriend occurred after she had "been really drunk," and she often missed early morning classes because of a hangover. She avoided illegal drugs ("I don't like to lose control, and alcohol is bad enough"). She had no criminal history. She did get paid to attend the BDSM parties, but "all I

did was look threatening, wear something skimpy, and spank these old guys. They wanted it and were so pathetic. Tying up my girlfriend was much more fun.”

Her childhood history was notable for having lived in foster homes before being adopted by the woman she calls her “intrusive but well-meaning mother.” She had memory gaps from her childhood and thought she might have been molested. “It would make sense, wouldn’t it? But I really don’t remember.”

Ms. Lundquist described sexual attraction to both men and women but preferred women because “they are typically more submissive.” When she masturbated, she fantasized about “power and control,” but she could not be more specific. She found herself attracted to her girlfriend’s brother and would probably date him “even if he’s not a sub.” (“Sub” typically describes a person who assumes a subservient, submissive role in the relationship, although appearances can be deceptive.)

Ms. Lundquist’s medical history was pertinent for having had scoliosis, for which, as a child, she was treated with a Harrington rod and spent a lot of time in the hospital.

On examination, Ms. Lundquist was guarded in the description of her emotions. She said that she had been “bummed out” since breaking up with her girlfriend, but she denied other symptoms of depression. She added that she was less upset about missing her girlfriend than about having to move back with her mother. She tended to stay up at night and sleep in. Her appetite fluctuated, and she occasionally put herself on crash diets to “prove I have control over my urges.” She had never been suicidal. She had thoughts of killing others and admitted to some “arousal” at the idea but had no plans or known targets. She had no delusions or hallucinations and no anxiety-related symptoms. She was intelligent and cognitively intact.

**Case 2.** Terry Najarian, a 65-year-old salesman for a large corporation, presented for a psychiatric evaluation after his wife threatened to leave him. Although he said he was embarrassed to discuss his issues with a stranger, he described his sexual interest in women’s undergarments in a quite matter-of-fact manner. This interest had surfaced several years earlier and had not been a problem until he was caught masturbating by his wife 6 weeks prior to the evaluation. Upon seeing him dressed in panties and a bra, she initially “went nuts,” thinking he was having an affair. After he clarified that he was not seeing anyone else, she “shut him out” and hardly spoke to him. When they argued, she called him a “pervert” and made it clear that she was considering divorce unless he “got help.”

Mr. Najarian’s habit began in the setting of his wife’s severe arthritis and likely depression, both of which significantly reduced her overall activity level and specifically her interest in sex. His “fetish” was the bright spot during his frequent and otherwise dreary business trips. He also masturbated at home but generally waited until his wife was out of the house. His specific pattern was to masturbate about twice weekly, using bras and panties that he had collected over

several years. He said that intercourse with his wife had faded to “every month or two” but was mutually satisfying.

The patient had been married for over 30 years, and the couple had two grown children. Mr. Najarian had planned to retire comfortably later that year, but not if the two choices were either to “split the assets or to sit around the house and be called a pervert all day.” He became visibly anxious when discussing his marital difficulties. He described some recent difficulty falling asleep and “worried constantly” about his marriage but denied other psychiatric problems. He had made a show of throwing away a half dozen pieces of underwear, which had seemed to reassure his wife, but he had saved his “favorites” and “could always buy more.” He said he was of mixed mind. He did not want to end his marriage, but he saw nothing harmful in his new mode of masturbating. “I’m not unfaithful or doing anything bad,” he said. “It just excites me, and my wife certainly doesn’t want to be having sex a few times a week.”

Mr. Najarian denied any difficulties related to sexual functioning, adding that he could maintain erections and achieve orgasm without women’s undergarments. He recalled being aroused when he touched women’s underwear as a teenager and had masturbated repeatedly to that experience. That fantasy had disappeared when he became sexually active with his wife. He denied any personal or family history of mental illness.

**Case 3.** Orren Vance was a 28-year-old man who was arrested after pushing a stranger in front of an oncoming subway train. He told police that he believed the man was going to “tell everyone that I was a faggot” and that he, Mr. Vance, was trying to protect himself from the “homosexual conspiracy.” Mr. Vance had a history of a psychotic disorder, a cocaine use disorder, and nonadherence to medication and psychotherapy at the time of the incident. Mr. Vance entered a plea of not guilty by reason of mental disease (the “insanity defense”) and underwent a full psychiatric evaluation, including assessment of his sexual history and desires.

As part of his legal case, Mr. Vance underwent a structured sex offender evaluation. He reported a long history of having sex with minors. His first sexual contact—with his uncle and an 18-year-old male cousin—was at age 12. By the time he was 14 or 15, he was regularly having sex with males and females who ranged in age from “about ten to probably in their thirties.”

He was unable to answer whether the sexual contact was always consensual, saying, “No one ever called the cops.” As an adult, he said that he preferred having sex with “young girls, because they don’t fight much.” He said that he usually only had sex with adults when he hired prostitutes or prostituted himself in exchange for money or drugs, although he said that sometimes when high, he “might have done stuff that I don’t really remember.”

The structured sex offender evaluation included penile plethysmography, assessment of visual reaction time using Viewing Time (a measure of the amount of time a person looks at a particular photo or other visual representation of a sexually stimulating situation), and detailed

interview about his sexual practices; it was determined that his main sexual attraction was to girls between the ages of 8 and 13 years.

Mr. Vance's personal history was significant for multiple childhood disruptions that led to his moving into the foster care system at age 7. At age 9, his first foster mother caught him repeatedly stealing toys and bullying other children. When she reprimanded him, he hit her with a brick, knocking her unconscious. That led to placement in a second foster home. He began using drugs and alcohol at age 11. He was first incarcerated at 13, for shoplifting from an electronics store in order to obtain money for marijuana. At that point, he went back to live with his maternal grandmother, who has episodically provided him a home since then. During those 15 years, he has been arrested at least a dozen times, mostly for drug possession.

Mr. Vance stopped attending school in eighth grade, at about the same time that he was admitted to his first psychiatric inpatient unit. That admission was triggered by his beating his head against a wall "to stop the voices." He was given a diagnosis of psychosis not otherwise specified, treated with risperidone, and discharged after 1 week. Soon after discharge, he discontinued the antipsychotic medication.

Between the ages of 15 and 28, Mr. Vance regularly abused cocaine and alcohol but also used whatever drugs became available to him. By the time of his arrest, he had had at least seven psychiatric admissions, always for auditory hallucinations and persecutory delusions (usually of a sexual nature). It was not clear which substances he was using prior to and during these episodes of psychosis or whether they were likely to be implicated in the development of his psychiatric symptoms. He had also been admitted twice for alcohol detoxification after he went into withdrawal while unable to acquire alcohol readily. He was consistently nonadherent to any type of outpatient treatment. His only periods of sobriety came while in hospitals or jails. When contacted by the consulting psychiatrist, his grandmother pointed out that Mr. Vance had always been "reckless, dishonest, and angry. I don't think I've ever heard him apologize. I love him, but he probably belongs in jail for lots of reasons."

**Case 4.** Wallace Pickering was a 29-year-old man who presented for outpatient therapy with a chief complaint of "I've never been to a shrink before, but I just read DSM-5, and I have ten diagnoses, including six paraphilias, two personality disorders, a substance use disorder, and maybe something from the appendix." The patient described himself as an attorney who "happened to be gay and have a few kinks." He had been dating a former college classmate for the prior 2 years. A native of a mid-size city in the Midwest, Mr. Pickering was raised in a politically and religiously conservative household that included his parents and two younger siblings. Mr. Pickering's father and grandfather ran a prosperous business, and his family was very involved in their community. Mr. Pickering attended an elite college and law school. Since graduation, he had worked at a large law firm. He added that he had been following DSM-5

controversies at least partly because of his boyfriend, who was in his final year of training to be a psychiatrist.

Mr. Pickering described his problems as being about “sex and drugs; I’ve never cared much for rock and roll.” Ever since high school, he described an interest in random sexual encounters. “Not to be narcissistic—though that’s one of my diagnoses—but I am kinda hot,” he said, “and I play it for what it’s worth.” This led him to frequent bathhouses and bars, where he could quickly connect to attractive, anonymous partners. He described feeling aroused when watching other people having sex and added that although he had quit the habit when he entered law school, he had previously gotten a thrill out of being watched while having sex. He said he had “hooked up” about once a month since age 20. He said he had never once had unsafe sex with anyone aside from his boyfriend, and this led him to mention another of his “diagnoses”: a fetishistic interest in rubber. He said condoms were great: they were virus proof, delayed ejaculation, and had an excellent smell. His interest in condoms had led him to get an outfit made entirely of rubber. He said it had been quite the hit at a bondage club, but it had made him so sweaty that he had worn it only once and had then thrown it away before his boyfriend found it. He said he also enjoyed tying up his boyfriend during sex and feeling completely in control. In addition to being a “sadistic top,” he said he also liked being a “bottom” and at other times did not feel sexual at all.

Mr. Pickering said that during his occasional pursuits of anonymous sex, he had a couple of “toxic habits.” Each night he was out he would do a few lines of cocaine and drink about six beers. He said he always timed these “trips to the underworld” for times when his boyfriend was on a business trip, his firm would be unlikely to suddenly call him back to work, and he would have a day to recover (“withdrawing from cocaine sucks”). He added that the planning had become more complicated and that he actually had probably only gone to a club twice in the prior year. Overall, his “social life is pretty boring, actually. We have a lot of friends, but we’re kinda like an old married couple. My only real vice is smoking. I have tried for years, but I haven’t been able to get down below half a pack a day. Yawn.”

When asked to say more about himself, Mr. Pickering answered, “Right . . . I almost forgot. I am obsessed by the hours that I work. I keep careful track so that I am among the top billers in the firm every month, and I always get my projects done on time, even if it means I don’t sleep. My own theory is that it’s part of my need to feel invulnerable and perfect despite being a mess on the inside.” Mr. Pickering paused, smiled, and continued. “That made me wonder if I’m obsessive-compulsive or narcissistic as well as having all the different paraphilias. Oh, and if hypersexuality gets into the appendix, then I’m really screwed.”

Toward the end of the initial interview, the psychiatrist said, “I’m not sure if any of these behaviors are going to make it as a diagnosis, but I am very interested in how you feel.” At that, Mr. Pickering welled up in tears and said he had felt sad and lonely all his life. He added that his

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family knew almost nothing about him, and that only a lesbian cousin—who had also moved to New York—knew that he was gay.

On examination, Mr. Pickering was a well-groomed, attractive young man who was coherent and goal directed. He smiled readily but showed an appropriate affective range. He denied suicidality, confusion, and psychosis. He was cognitively very bright. His insight and judgment were viewed as intact.

**Resources for survivors who have experienced sexual abuse, sexual assault, or other sexual misconduct**

- **Darkness to Light**  
By phone: (866) 367-5444. Toll-free helpline for individuals living in the United States who need local information and resources about sexual abuse.
- **National Center for Victims of Crime**  
By phone: (800) 394-2255. Toll-free helpline offers supportive counseling, practical information about crime and victimization, and referrals to local community resources, as well as skilled advocacy in the criminal justice and social service systems.
- **Rape, Abuse & Incest National Network**  
By phone: (800) 656-4673. Toll-free National Sexual Assault Hotline.  
Online: <http://www.rainn.org/get-help/national-sexual-assault-online-hotline> Instant-messaging format National Sexual Assault Hotline.  
Both hotlines are free and available 24 hours a day, 7 days a week, and offer secure, anonymous, confidential crisis support for victims of sexual assault and their friends and families.
- At JMU: [Campus Coalition Against Sexual Assault](#) includes resources for reporting sexual assault on campus, as well as links to Title IX office and campus supports.

**Academic resources and further reading**

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**Appendix B. Slides**



# Seminar in Paraphilic Disorders

Kim E. Hall  
James Madison University



# What is a Paraphilic Disorder?

- Much commentary on this
  - Cultural/social/temporal aspects of defining a paraphilia- see homosexuality in the DSM until 1973
  - Definition right now is “an intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners” (APA, 2013, p. 685). What does this mean?
  - Paraphilic “disorder” contingent on acting on a non-consenting person, or clinically significant distress- but distressed how?

# What is a Paraphilic Disorder?

- How “abnormal” are paraphilic desires?
- Are we abusing the the idea of paraphilic disorders?
  - Other Specified Paraphilic Disorder/Paraphilia NOS
- How do we make sure others are protected while serving the best interests of our clients?

(Ross, C.A. 2015, Defeo, J., 2015, McManus, M.A. et al, 2013)

# Prevalence

Diverse presentation in the population: “people with paraphilias come from all ethnic and socioeconomic backgrounds as well as from all levels of intelligence. In addition, their sexual orientation may be heterosexual, homosexual, or bisexual” (Seligman & Hardenburg, p. 107).

# Prevalence

- Prevalence is difficult to determine
  - What are some reasons for this?
- Projected prevalence of paraphilic interests (not necessarily disorders!) is possibly over half the population
- Psychological comorbidities often present

(Dawson, S.J. et al. 2016, Joyal, C. & Carpentier, J. 2016, Marsh, P.J. et al. 2010, Seligman, L. & Hardenburg, S.A. 2000)

# Prevalence

- More common in men than women
- Why might this be? Could we see a difference in male/female diagnosis rates because we don't have a consistent idea of paraphilia/paraphilic disorder?
  - We conceptualize male and female sexual abnormality differently, according to some
  - We define paraphilic disorders in terms of crimes

(Beech, A.R. et al., 2016, Joyal, C. & Carpentier, J. 2016, Dawson, S.J. et al. 2016, Duschinsky, R. & Chachamu, N., 2013, Wijkman, M. et al. 2010)

# Causes

- Not well understood
- Theories include:
  - Exposure to dysfunctional family environment in childhood- disorganized attachment, abuse
  - Biological origins/heritability of paraphilic interests
  - Mechanical brain damage
  - In-utero exposure
  - Classical conditioning
  - Early sexual experiences
  - What other potential causes?

(Labelle, A. et al., 2011, Bianchi-Demicheli et al., 2010, Seligman, L. & Hardenburg, S.A., 2000, ISSM)

# Why this class?

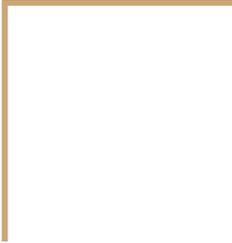
- It's good to know how your client will be conceptualized by courts, society, partners, self, and yourself
- What might your paraphilic disordered client be like?
- Concept of "forensic utility"
- Ideas for advocacy
- Determining treatments/course of therapy

# Treatment planning

What to do when...

- Client is distressed?
- Client comes through criminal justice system?
- Something else- client just revealed this to me?

(Garcia, F.D. et al 2013, Rice, M.E. & Harris, G.T. 2011)



# The Disorders



# A note on data gathering

- Most of the data presented in the DSM-5 on paraphilic disorders is specified to come from adult males in forensic settings- why?
  - Remember: criteria for paraphilic disorders are 1. Engaging in an inappropriate act and 2. Having clinically significant distress or impaired functioning

(Joyal, C.C. & Carpentier, J., 2016, American Psychiatric Association, 2013)

# Voyeuristic Disorder

- Diagnostic Criteria
  - Over at least 6 months, recurrent and intense sexual arousal from observing unsuspecting person undress/naked/engage in sexual activity
  - Either acted on these urges w/ nonconsenting person [committed sex offense] or displays clinically significant distress/impairment
  - Must be at least 18
    - Controlled environment: criteria met within an institutional setting
    - In full remission: has not acted on urges w/ nonconsenting person or had clinically significant distress for at least 5 years in uncontrolled environment

(American Psychiatric Association, 2013)

# Voyeuristic Disorder

- Prevalence
  - Onset in adolescence
  - High range for men: 12%
  - High range for women: 4%
  - Actual prevalence of voyeurism, disordered or not, unknown
- Risk factors include voyeurism, childhood sexual abuse, hypersexuality of different origins

(American Psychiatric Association, 2013)

# Voyeuristic Disorder

- Differential should include antisocial personality disorder, conduct disorder, substance use disorders [any others?]
- Common comorbidities
  - Other paraphilic d/o (exhibitionism)
  - Depressive, bipolar, anxiety, substance abuse, ADHD, antisocial personality

(American Psychiatric Association, 2013)

# Voyeuristic Disorder

- Treatment
  - CBT
    - Shows some success at preventing recidivism in offenders
  - Pharmacological agents
    - Anti-androgens, psychotropic agents have minimal effectiveness
    - Gonadotropin-releasing hormone treatment (chemical castration): effective
  - Behavioral therapies (conditioning, etc)
    - Minimal effectiveness

(McManus, M.A. et al. 2013)

# Voyeuristic Disorder

- Treatment planning
  - Distress, offense, both?
  - Build tolerance, knowledge, coping skills? Prevent action, recidivism?
  - When might you need to report?
  - Forensic utility?

# Exhibitionistic Disorder

- Diagnostic Criteria
  - For at least 6 months, recurrent/intense sexual arousal from exposure of genitals to unsuspecting others
  - Acted on urges w/ non-consenting person, or clinically significant distress or functional impairment
  - Specifiers
    - Exposure to prepubertal children
    - Exposure to physically mature persons
    - Both
    - Controlled environment (institution)
    - Full remission (no inappropriate action or distress for at least 5 years)

(American Psychiatric Association, 2013)

# Exhibitionistic Disorder

- Prevalence
  - Onset in adolescence
  - Possibly up to 4% of males
  - Likely to be much lower in females (almost no clinical presentation of the disorder)
  - Prevalence of exhibitionism in general, disordered or otherwise, is unknown
    - Recall that exhibitionistic d/o is showing of genitals to unsuspecting others; exhibitionism can mean more things

(American Psychiatric Association, 2013)

# Exhibitionistic Disorder

- Risk factors: exhibitionism, childhood sexual abuse, hypersexuality
- Comorbidities and differential are the same as voyeuristic disorder
- Treatment options are the same
  - Forensic utility?

(American Psychiatric Association, 2013)

# Frotteuristic Disorder

- Diagnostic criteria
  - For at least 6 months, recurrent/intense sexual arousal from touching or rubbing against non-consenting persons
  - Acted on w/ non-consenting person, or clinically significant distress/functional impairment
  - Specifiers
    - Controlled environment (institution)
    - Full remission (no inappropriate act or distress for at least 5 years)

(American Psychiatric Association, 2013)

# Frotteuristic Disorder

- Prevalence
  - Acts of frotteurism may be committed by up to 30% of male population, but it's difficult to know for sure
  - About 10-14% of males being treated for a paraphilic disorder are being treated for frotteuristic disorder- general population prevalence probably doesn't exceed this
  - Female prevalence is much lower

(Tanaka et al. 2017, American Psychiatric Association, 2013)

# Frotteuristic Disorder

- Risk factors/comorbidities
  - Frotteurism, antisocial behavior
  - Comorbidities are the same as voyeuristic and exhibitionistic disorders
  - Differential?
- Treatment options are the same as voyeuristic or exhibitionistic disorder
  - Forensic utility?

(American Psychiatric Association, 2013)

# Sexual Masochism Disorder

- Diagnostic Criteria
  - For at least 6 months, recurrent/intense sexual arousal from being humiliated, beaten, bound, otherwise made to suffer (urges, fantasies, behaviors, pornography use)
  - Clinically significant distress or functional impairment
  - Specifiers
    - With asphyxiophilia (arousal related to restriction of breathing)
    - Controlled environment (institution)
    - Full remission: no significant distress or impairment for at least 5 years
- What do you see that is different from previously described disorders?

(American Psychiatric Association, 2013)

# Sexual Masochism Disorder

- Prevalence
  - Onset as early as prepubescence but generally in late teens
  - Disorder prevalence is unknown
  - 1-3% of general population possibly engages in masochistic acts
  - Less difference between women and men

(American Psychiatric Association, 2013)

# Sexual Masochism Disorder

- Risk factors/comorbidities
  - Masochism is the biggest predictor
  - Other paraphilic disorders/paraphilias are frequently comorbid
  - Differential?
- Treatment
  - What is the treatment for someone with distress or functional impairment?
  - Forensic utility?

(American Psychiatric Association, 2013)

# Sexual Sadism Disorder

- Diagnostic Criteria
  - For at least 6 months, recurrent/intense sexual arousal from physical or psychological suffering of another person (fantasies, behaviors, urges, pornography)
  - Acted on urges w/ non-consenting person, or clinically significant distress/functional impairment
  - Specifiers
    - Controlled environment (institution)
    - Full remission: no inappropriate acts or distress for at least 5 years

(American Psychiatric Association, 2013)

# Sexual Sadism Disorder

- Prevalence
  - Onset as early as prepubescence, but generally in late teens
  - 2-30% of the general population has interest/has engaged in sexual sadism, actual disorder prevalence unknown
  - Less than 10% of sexual offenders
  - Among those who committed sexually motivated homicides, prevalence may be up to 75%
  - Less difference between women and men than other paraphilic disorders

(American Psychiatric Association, 2013)

# Sexual Sadism Disorder

- Risk factors/comorbidity
  - Sexual sadism as biggest risk factor
  - Comorbid with other paraphilic disorders
  - Differential?
- Treatment
  - Prevention of recidivism in offenders and/or reduction of distress/dysfunction
  - Forensic utility?

(American Psychiatric Association, 2013)

# Pedophilic Disorder

- Diagnostic Criteria
  - For at least 6 months, recurrent/intense sexual arousal, fantasies, urges, or behaviors involving sexual activity with prepubescent child/children (generally under 13) [note forensic utility]
  - Acted on these urges, or urges cause significant distress/interpersonal difficulty
  - Must be at least 16, at least 5 years older than child/children
    - Do not include individuals in late adolescence involved in an ongoing sexual relationship with a 12- or 13- year old
  - Specifiers
    - Exclusive or nonexclusive type
    - Males, females, or both
    - Limited to incest

(American Psychiatric Association, 2013)

# Pedophilic Disorder

- Prevalence
  - Onset generally in puberty; age criteria in place to distinguish between pedophilic disorder and sexual exploration w/peers
  - General population prevalence unknown but up to 3-5% of males seems to be the high end, likely a lower rate in women
  - Diagnostic considerations: use of porn, physiological arousal

(American Psychiatric Association, 2013)

# Pedophilic Disorder

- Risk factors/comorbidities
  - Childhood sexual abuse, antisocial personality traits, pedophilia, neurodevelopmental injury/delay
  - Differential includes antisocial personality disorder, substance use disorders, obsessive compulsive disorder- why?
  - Comorbidities: antisocial personality disorder, other paraphilic disorders, depression, bipolar, anxiety, substance abuse disorder

(American Psychiatric Association, 2013)

# Pedophilic Disorder

- Reporting
  - Who knows how to report a case? To whom? When?
- Treatment
  - Some believe too much of the focus on pedophilic disorder is on punishment, rather than treatment or prevention
  - What are some societal/cultural barriers to identifying and researching treatment methods? What are the barriers to offering these treatments to individuals w/ pedophilic disorder?

# Pedophilic Disorder

- Treatments tried:
  - Sexual reconditioning (conversion therapy?)
  - Prevention
  - Psychopharmacological agents, chemical/surgical castration
  - CBT, adventure therapy
  - Multisystemic therapy (study in youths)- “integrates structural and strategic family therapies, behavioral parent training, and cognitive-behavioral interventions to reduce adolescent antisocial behaviors” (Dopp, A.R. et al. 2017, p. 635)
  - What else would you try?

(Dopp, A.R. et al., 2017, Malone, L., 2014)

# Fetishistic Disorder

- Diagnostic Criteria
  - For at least 6 months, recurrent/intense sexual arousal from either the use of nonliving objects or a highly specific focus on non-genital body parts (fantasies, urges, behaviors, collecting or extensively utilizing objects)
  - Clinically significant distress or impairment in daily functioning
  - Objects cannot be limited to clothing used in cross-dressing (transvestic disorder criteria) or objects designed for genital stimulation (sex toys)
  - Specifiers
    - Body part(s), Nonliving object(s), Other
    - Controlled environment (institution)
    - Full remission (no distress or impairment for at least 5 years)

(American Psychiatric Association, 2013)

# Fetishistic Disorder

- Prevalence
  - Onset variable, prepubescent-onward
  - Not established in the DSM-5, one study of 112 psychiatric inpatients found 1 person who'd ever had this dx
  - Apparently almost exclusively in males
  - DSM-5 urges cultural competence- why?
  - Theories include conditioning, occasionally neurologic/mechanical brain damage conditions

(American Psychiatric Association, 2013, Bianchi-Demicheli et al., 2010, Marsh et al. 2010, ISSM)

# Fetishistic Disorder

- Differential/comorbidities
  - Differential includes transvestic disorder, other paraphilic disorders, other non-disordered paraphilic behavior
  - Comorbidities may include other paraphilic disorders or neurologic conditions
- Treatment
  - Treating associated distress/danger and/or interpersonal dysfunction
  - Forensic utility?

(American Psychiatric Association, 2013)

# Transvestic Disorder

- Diagnostic criteria
  - For at least 6 months, recurrent/intense sexual arousal from cross-dressing (urges, fantasies, behaviors)
  - Clinically significant distress or impairment in daily functioning
  - Specifiers
    - With fetishism (fabrics, materials, clothes are arousing, less correlated with gender dysphoria)
    - With autogynephilia (idea of self as female is arousing, more correlated with gender dysphoria)
    - Controlled environment (institution)
    - Full remission (no distress or impairment for at least 5 years)

(American Psychiatric Association, 2013)

# Transvestic Disorder

- How is this different from being transgender/femme or masc/non-binary/other gender presentation or identity?
  - Wearing of opposite sex clothing is ALWAYS accompanied by sexual arousal, AND
  - There is clinically significant distress or functional impairment caused by this
    - Interpersonal sexual dysfunction
    - Shame, stigma
    - Gender dysphoria (controversial)
      - Gender dysphoria is not diagnostic of transvestic disorder
      - Gender identity and sexuality are different things
      - Controversy over term “autogynephilia”

(Jones, Z., 2016, American Psychiatric Association, 2013)

# Transvestic Disorder

- Prevalence
  - Onset as early as prepubescence
  - One study returned figure of 2.8% of males using term “transvestic fetishism”
  - Almost exclusively seen in males
- Differential/comorbidities
  - Differential includes fetishistic disorder, gender dysphoria (also possibly comorbid)
  - Other comorbidities include other paraphilic disorders or behaviors, including masochistic disorder and behaviors
- Treatment
  - Treat interpersonal dysfunction and personal distress
  - Forensic utility?

(American Psychiatric Association, 2013, Marsh et al., 2010)

# Other Specified Paraphilic Disorder

- Any paraphilic symptoms that meets the standards for a disorder
  - Duration of at least 6 months
  - Action on or with a non-consenting person
  - Clinically significant distress or functional impairment
- What are some paraphilic symptoms that might be included here?
  - Forensic utility?

(American Psychiatric Association, 2013, Thornton, D., 2010)

# Unspecified Paraphilic Disorder

- Catch-all for situations without sufficient information to make another diagnosis, but that include paraphilic symptoms and associated clinically significant distress, impairment, or harm

(American Psychiatric Association, 2013)

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