Aspects of Sexual Medicine

Management of Sexual Deviation

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Few men go to their doctor complaining of a sexual deviation, and those who do are usually impelled by fear of discovery or pressure from their family or the law. Many who experience guilt or anxiety about their deviant sexual practices present their doctor with a variety of complaints and hope that he or she will perceive their underlying concern or provide them with an opportunity to reveal it. An unknown number seek help from the plethora of sex shops, counselling services, and special-interest self-help groups, which vary greatly in their competence and credibility. In a single article it is not possible to consider elaborate definitions or to explore current theories nor is it helpful to produce an extensive catalogue of the almost infinite variety of perversions practised by man. Instead I will try to outline some general principles of management.

Blind Spots

To function effectively as medical advisers in sexual problems we require both knowledge and a degree of self-understanding. Knowledge can be acquired from a number of excellent books largely available as paperbacks and from lectures at post-graduate centres, but insight into one's own attitudes, inhibitions, and prejudices is more difficult to achieve. We are all prisoners of our past in the sense that family attitudes, religious training and beliefs, actual experience, expectation, joy, and disappointment have subtly moulded our attitudes to ourselves and others. Without an opportunity for frank discussion of the problems of human sexuality in a group of our peers few of us will ever perceive our own blind spots. If the only person a doctor ever talks to about sexual matters is the individual seeking advice, a confrontation rather than a consultation will result. The Family Planning Association and other groups have arranged on-going seminars on sex problems which provide an ideal training opportunity, but at a less sophisticated level much is to be gained by more informal opportunities to meet colleagues and discuss specific texts or individual clinical problems. As in many other areas of medical practice there will be practitioners who for personal, ethical, or other reasons wish to opt out of the management of particular forms of deviance. It is then important that they should recognize their obligation to advise the patient to seek specific help elsewhere.

A crucial skill is the doctor's willingness to listen and his ability to hear. He needs to help the patient to feel at ease and to encourage without impeding the flow of his statement, but he needs to be sensitive to, to hear, the hint of the underlying

problem. An encouraging nod to "It's all right, isn't it Dr." when one is not clear just what the patient is talking about may lose forever an opportunity to glimpse the unspoken problem. A non-judgemental, sympathetic concern for the patient's problems is essential and does not imply condoning or encouraging behaviour which one believes to be harmful. However, the time for discussing the implications of the behaviour is at the end of taking the history, when full formulation of the problem is possible and the time to discuss management has arisen. There will be rare circumstances when the patient's deviation carries serious risk to others, and then the doctor may have an overriding responsibility to society which justifies a breach of confidence. These cases are rare and usually there is time to seek the advice of an expert from one of the medical defence societies and to discuss the problem with more experienced colleagues.

Full History

Once the problem has been identified and the patient assured of the doctor's concern and willingness to help it is advisable to proceed, if necessary over several consultations, with taking a full history. This includes a review of the patient's early family life and social background, his psychological development, and a detailed account of his own sexual development including his early sex education and experience. Particular attention should be paid to his sexual phantasy both early and current. Whatever the deviation, the prognosis is much improved if at any time in the past successful heterosexual intercourse has been established.

The role of phantasy in the shaping and fixing of sexual deviation has been seriously underestimated. There is little doubt that the human male orgasm, with its very close temporal relationship between excitation and orgasm, is readily conditioned, and, even in individuals whose learning or conditioning is defective, repetition in phantasy of the exciting stimulus can lead to firmly developed behaviour patterns. It seems likely that whatever the exciting stimulus the phantasy or thought picture present in the few seconds before orgasm and ejaculation is a powerful factor in conditioning, and this has important implications in the treatment of sexual deviation. At its simplest level any deviant wishing to give up his practice should be encouraged, whatever the stimulus to erection or the method of achieving orgasm, to think of normal heterosexual intercourse in the five or six seconds before emission.

Sexual deviations are largely confined to the male but exist at every physical, social, and intellectual level. The more esoteric deviations tend to come to light first among the more creative, gifted, intellectual members of society, but this probably represents their drive and effectiveness in securing public attention rather than the true prevalence of the particular deviance. A high proportion of sexual deviants seen in clinical practice have other evidence of personality disorder, possibly related to their greater reliance on phantasy in sexual relations owing to their difficulty in establishing more intimate relationships in real life.

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Commonest Deviation

This is clearly evident in the commonest deviation likely to come to the attention of the practitioner, namely, exhibitionism. The Vagrancy Act of 1824 asserts that "every person who wilfully, openly lewdly and obscenely exposes his person with intent to insult any female is a rogue and a vagabond." About 3000 men are charged every year with indecent exposure, making it the commonest type of sexual offence committed by adults. The behaviour tends to begin in the late teens or early twenties and becomes decreasingly common in men over 40 years of age, so that late onset should always raise the suspicion of a major psychiatric disorder such as dementia, psychosis, or drug (including alcohol) abuse. The offender tends to be inhibited, unassertive, and generally immature, often with a prickly sensitivity to minor slights or upsets. Though the full range of intelligence and social class is represented, the exhibitionist is often an underachiever, reluctant to accept responsibility, and easily deterred from achieving his goals. He often has a sexual partner of whom he may be extremely jealous, and he may tend to exhibit himself when upset by or separated from her.

Most exhibitionists will seek out adult female victims and avoid threatening behaviour or any physical contact with them. Their behaviour often appears to be compounded of a primitive search for reassurance about their masculinity and the experience of intense excitement and fear of arrest with a sense of exhilaration and achievement after a successful exposure. When children are invariably sought out there is some risk of future sexual assault, and any act of exposure followed by sexual advances towards the victim must be treated as more serious.

TREATMENT

Though imprisonment or punitive fines fail to modify this deviation, the vast majority of men actually charged with the offence are not reconvicted. The shock of a court appearance may be sufficient to enable them to control their impulses, and a probation order ensures regular supervision which is otherwise difficult to achieve, for these men are notably lacking in persistence in seeking treatment.

Regular supervision with simple counselling sometimes directed towards enabling the patient to recognize and express anger and generally to assume a more assertive role in his interpersonal relationships may be sufficient to prevent relapse. In patients without other sexual outlets simple advice and instruction on masturbation, emphasizing the need for normal heterosexual phantasy, will reduce the pressure to exposure. Psychotherapy and behaviour therapy may be successful in resistant cases but these are matters for a specialist clinic. Hormone therapy has followed castration into oblivion as a form of treatment. Recently benperidol has been claimed to be effective in controlling deviant sexual behaviour, but it is too early to assess these claims adequately. Cyproterone acetate is an oral anti-androgen which in a dosage of 100 mg per day effectively reduces or abolishes sexual drive and has also been recommended in the treatment of exhibitionism. However, in a condition which may reflect anxiety about potency the effects of a chemical reduction in libido will have to be observed over a long period before this can be confidently recommended as a routine treatment.

Stimulus and Phantasy

Masturbation should not be regarded as a sexual deviation unless it is the exclusive and preferred mode of sexual expression in an adult or the compulsion to masturbate is so frequent as to cause inconvenience and distress to the individual. Yet masturbation remains a source of great anxiety to many men who can be reassured with confidence. It is important, however, to recognize the possible role of masturbation in shaping sexual

behaviour, for a chance stimulus which is associated with sexual excitation may be recreated in phantasy when erection and ejaculation occur. On subsequent occasions the phantasy is elaborated and modified, so that gradually considerable changes occur in the habitual arousing phantasy and in the desired sexual behaviour. This is probably an important factor in the development of fetishism.

A developing boy may be aroused to erection and emission by a wide variety of non-specific stimuli. Fear or any other state of arousal, tactile experiences, accidental viewing of apparently taboo subjects such as the sight of mother or sister in under-clothing, or almost any object may be the initial stimulus which is recreated, elaborated, and shaped in subsequent phantasy. Though probably more likely to evolve as a result of early experience, fetishism may develop in adult life. This compulsive, irrational sexual attraction to a part of the body or object or a symbolic substitute for a person may be partial or complete. Some degree of fetishism is extremely common, and elaborate preoccupations with the pattern of foreplay or the dress and setting of either or both parties is apparently found acceptable by many couples. When the total sexual activity of the individual is discharged in relation to the fetish or when distress is caused to the other partner, the individual is more likely to seek help. The fetishist may come to attention because he steals the articles which attract him.

When an individual seeks help because of fetishism simple explanation and support should be offered. He should be firmly discouraged from indulging in the fetish and encouraged to seek normal sexual outlets. When he is unable to resist, he should be urged to focus on normal heterosexual phantasy for five or six seconds before emission. When such measures fail, behaviour therapy is often extremely effective, but an expert should be consulted in order to devise a programme which can be followed in the general practice or clinic.

Transvestism

When the preoccupation with female garments extends to the actual wearing of the garments the condition merges into transvestism, which is the subject of considerable controversy. Broadly, transvestism may be fetishistic or non-fetishistic. In the former sexual excitement and often masturbatory rituals are associated with the act of dressing. This is usually a solitary practice, but often the individual eventually wishes to appear in public yet retaining and usually in the end disclosing his male identity. In this condition I believe the individual should be encouraged to seek specialist help, and behaviour therapy or psychotherapy has a good prospect of success.

In the non-fetishistic form of transvestism the individual experiences not excitation but contentment when dressed up, and after pursuing his masculine activities during the day he will relax at home in the evening in his female dress. It is sometimes argued that this is not a form of sexual behaviour nor a form of gender disorder, and organizations such as the Beaumont Society exist to support and advise those who prefer this mode of behaviour. This pattern merges into the more extremely deviant group, the transsexualist, in which a true disorder of gender identity exists. Such people believe themselves to be female souls trapped by some cruel freak of nature in a male body. They wish not only to dress as women but to be accepted in every way as women, and they will press to have their body modified by surgery or hormones to approximate the female form. These patients should always be referred to a specialist clinic for investigation and treatment.

Attraction to Children

A sexual attraction to children of either sex must always be taken seriously, but it is important to distinguish between paedophilia and curiosity or a craving for human contact in a

mentally dull or socially isolated individual. Exploratory behaviour motivated by curiosity or a craving for physical contact may appear in dull or emotionally immature people and, if encouraged may pass on to mutual masturbation or other activities. Such behaviour should of course be firmly discouraged, but even in very young boys a sharp distinction should be made between those who are coercive, aggressive, or rough in their approach to another child and those lacking in aggression. Any tendency to aggressive behaviour calls for urgent, specialized intervention and close supervision, for the risk of physical harm to the victim is great. In the treatment of the non-aggressive offender explanation, education, adequate supervision, and the provision of appropriate opportunities for social contact may be sufficient. If doubt exists, the patient should be referred to an appropriate clinic.

Indefinite Borderlines

The variations of sexual deviance and perversity are enormous, and the borderlines between normal and abnormal, between acceptable and unacceptable, are difficult to define. Many sexual deviations cause guilt, distress, and remorse to the individual, his family, and, where others are involved, to his victim. Whether the deviance is best explained in behavioural or

psychopathological terms, it is extremely difficult for the individual to overcome it alone, yet he is reluctant or ambivalent in seeking help and accepting treatment. Once he presents his problem, usually in response to some specific stress, he should be encouraged to involve his family or sexual partner in helping him overcome his difficulties. When an offence has been committed a probation order can be added to family pressure to keep the individual in treatment. Ventilation of the problem, understanding of its nature and its seriousness by the doctor, and sympathetic but firm advice will often enable the individual to overcome his deviant impulses.

It is imperative, however, that sufficient time and regular opportunity for discussion, encouragement, and follow-up are allowed, for if the initiative is left to the patient he is likely to drop out. The doctor should beware of the patient who uses the consultation to elaborate and titillate his phantasies and has no intention of abandoning his deviant outlets. If simple measures are ineffective, expert advice should be sought from a psychiatrist or other colleague with a special interest in these problems.

Some groups in society are critical of the role of the physician in treating deviants, accusing him on the one hand of pandering to bizarre sexual appetites and on the other of acting as a punitive agent compelling the individual to conform to the arbitrary norms of society. In my view the management of these cases calls for the exercise of the full range of the skills of the physician. They provide him with an opportunity to alleviate real suffering

Letter from . . . Chicago

Confrontations

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The passing by Congress of the largest tax cut in American history, much larger than originally requested by the President, has touched off speculations about an early national health insurance bill; but the Administration's resolve to keep the budget deficit within acceptable bounds may thwart further action this year, and even the proposed medical assistance for the unemployed has not yet materialized. Work on a comprehensive health insurance programme, however, is expected to begin shortly, because any plan approved would take at least a year to implement. Meanwhile, government control over medicine steadily increases with regulations on planning, utilization review, and use of drugs. Indeed, apart from benefits for some groups presently uncovered, the main pieces of a national health scheme may already be in place.

The growing malpractice crisis may provide further opportunity for federal intervention, a prospect opposed by "organized medicine" in favour of local legislation such as has already been passed in several states. This is just as well, because centralized federal programmes tend to become unwieldy and wasteful—a consequence, at least in part, of what many think is the all-too-

frequent inclination to solve social problems by relying on money rather than intelligence, imagination, and common sense. An estimate, for instance, of the cost of the new utilization review procedure is that it could easily reach \$500 million a year, and already some of the newly established professional service review organizations are reportedly unable to continue their function because of the recent shortage of federal funds.

Pie in the Eye

By contrast, the evidence increases that only federal legislation to ban the sale, manufacture, and possession of handguns will ever stop the unprecedented carnage in our streets. Last year more than 100 gun laws were introduced in Congress, but none were passed. This year the chances are brighter, and congressional hearings are now being held on the subject. And, since crime has come to dominate so much of our lives, it is probably worth reporting that a new form of violence has gripped the nation: pie violence. The trouble originated in Washington, where a trail of rhubarb and meringues leads to the headquarters of the now infamous Pie Face International. The facts are simple: for \$60 the association will arrange to throw a pie in the face of any chosen victim, whether the motive be overt fury, suppressed rage, or a marital love-hate relationship.

In Chicago two episodes have occurred in the full glare of the television cameras. In one a well-known columnist settled an old score with a television weatherman; in another a reporter, sent

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