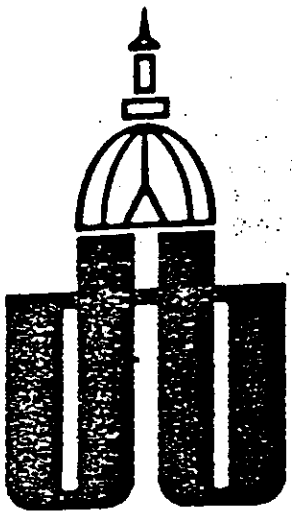

Psychiatric Clinics at The Johns Hopkins Hospital

Larry E. Tune, editor

Sexual Deviation Syndromes

FRED S. BERLIN AND GENEVIEVE S. COYLE

Department of Psychiatry and Behavioral Sciences, The Johns Hopkins Hospital, Baltimore, Maryland

CASE PRESENTATION (VOYEURISM)*

The patient, a white man in his early forties, entered hospital in the fall of 1980 to begin treatment for voyeurism. Although he had experienced the urge to spy upon naked or partially clad women as early as age 6, it was not until his late teens that this interest became a consuming preoccupation. Since his late teens, he had spent as many as five or six evenings a week "peeping" through windows at women disrobing, usually masturbating himself while doing so. Never desiring further contact with any of them, he never attempted entry into a home, nor had he wished to be observed while watching.

The patient found voyeurism more erotically arousing than sexual intercourse with a consenting partner. Voyeuristic urges were with him much of the time, and he reported frequently having to make an effort to inhibit erection when in the presence of an attractive female.

Voyeurism, usually performed alone, but occasionally with a group of other men, caused him numerous problems over the years. While in college, the amount of time consumed "peeping" caused decreased academic performance, and similar activities during his second term in the Navy led to a less than honorable discharge.

* Case discussed at Psychiatric Grand Rounds, February 2, 1981.

Reprint requests to Dr. Fred S. Berlin, Phipps 235A, The Johns Hopkins Medical Institutions, Baltimore, Maryland 21205

His first wife committed suicide, possibly in part as a response to discovery of his sexual predilections. His second wife obtained a legal separation after discovering that he had been masturbating while watching his daughter sleeping, a behavior that troubled him a great deal afterwards, once his sexual desires had been relieved by orgasm. Although arrested twice for voyeurism, once in 1967 and again in 1976, he had never broken the law in any other way; he is responsibly employed; and he is otherwise a pleasant and conscientious person. A devout man of above average intelligence, he had often prayed for "divine inspiration to help solve his problem." In spite of compulsory court-ordered psychotherapy following each of his arrests, he continued experiencing voyeuristic urges until hospitalization. Upset about the recent separation from his wife, the patient had referred himself for hospitalization. He had not been apprehended recently and was facing no legal charges at the time of admission.

Family history was unremarkable except that his father was 69 years old when the patient was born, and during childhood the patient had been separated from his mother for five years after she contracted tuberculosis. Physical examination was essentially normal, but his luteinizing hormone (LH) level was 98 ng/ml (normal, 36–64).

While still hospitalized the patient began treatment with weekly intramuscular injections of 500 mg of medroxyprogesterone acetate, which suppressed his serum testosterone to below normal levels. For the last seven months he has continued weekly injections on an

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outpatient basis. Since the third week of treatment he has been reporting relief from incessant voyeuristic urges and thoughts, along with cessation of related behaviors. He and his wife have reunited, and he has been speaking to church groups and other interested organizations about his apparent success in treatment.

DISCUSSION

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM III), voyeurism involves the repetitive seeking out of situations in which an individual observes unsuspecting women who are either naked, in the act of disrobing, or engaging in sexual activity (1). The act of looking ("peeping") is accompanied by sexual excitement, frequently with orgasm, usually produced concurrently by masturbation, or later in response to the memory of what was witnessed. Further sexual contact does not occur, with the memory or act of looking, rather than intercourse, constituting the final basis for sexual gratification.

Approximately 25% of known voyeurs are married, dramatizing the desire of these men to spy upon women who do not know they are being observed. Although voyeuristic behavior usually begins around puberty, related fantasies may be experienced much earlier. Untreated, the behavior is ordinarily chronic, which is not surprising since it is sexually motivated, and the sex drive does not cease. Factors predisposing to development of voyeurism are unknown, with associated complications usually resulting from discovery or arrest. The prevalence of voyeurism in the general population has not been ascertained, but thus far it has been reported only in men. Visual stimulation can be an integral part of conventional sexual activity, but in those instances optimal sexual arousal does not require that the observed partner be unsuspecting, nor is observing the final desired act.

Rationale for Treatment

Voyeurism is classified as one of the paraphilias (sexual deviation disorders). Other paraphilias include pedophilia (sexual craving for children), exhibitionism, transvestism (cross dressing for erotic pleasure), zoophilia (sexual attraction towards animals), erotic masochism, and raptophilia (paraphilic, or compulsive, rape). Behaviors engaged in by persons manifesting one of these syndromes can bring them into conflict with the law, raising the issue of whether punishment or treatment is more appropriate. In considering the possibility of treatment one must try to determine whether the behavior in question was an expression of a recognizable and treatable psychiatric syndrome (2). Not all sex offenses (a legal term) are committed by persons manifesting a sexual deviation disorder, or paraphilia (a medical term). Sex offenses can be committed for a variety of reasons depending upon the state of mind that led the offender to act.

Some sex offenders may be treatable even when their behavior is not the manifestation of a sexual deviation disorder, but rather the reflection of another psychiatric condition. For example, rape could be perpetrated by a deluded person out of touch with reality, responding to the auditory hallucinations of schizophrenia. In this case, phenothiazine medication might be helpful, whereas lithium carbonate might aid the person responding in a sexually inappropriate manner to the heightened erotic appetite of mania. Treatment with antabuse and counseling might benefit the alcoholic who becomes sexually disinhibited when intoxicated, and education might be useful to the mentally retarded individual who must learn to express his sexual urges appropriately.

In contrast to the examples just cited, some sexual offenses are enacted as a response to intense and persistent unconventional sexual cravings, that is, secondary to a sexual deviation disorder. Most men with conventional heterosexual interests have no desire for erotic intimacy with a seven-year-old boy (as does the homosexual pedophile), or to expose themselves repeatedly on a street corner (as does the exhibitionist). In addition, few men experience an overwhelming desire to peek in windows—a desire sufficiently intense to lead to repeated risk to job, reputation, family, and possibly encarceration. Thus, the belief that exhibitionists, paraphilic rapists, pedophiles, or voyeurs are simply "normal, self-indulgent men" with conventional sexual interests, men who are merely misbehaving (requiring punishment rather than treatment) seems incorrect, as well as rehabilitatively ineffectual.

Diagnosis

Diagnosis of a sexual deviation syndrome can be made by examining a person's thoughts, feelings, and behavior. Persons with sexual deviation syndromes such as pedophilia or voyeurism experience repeated persistent fantasies about unconventional sexual activities. The homosexual pedophile (often impotent with women), repeatedly fantasizes about young boys, whereas the voyeur is preoccupied with thoughts of "peeping." Asking an individual about his masturbatory fantasies can give a clue regarding his sexual interests, because erotic arousal and erection for the purpose of masturbation may be difficult in the absence of sexually stimulating mental imagery.

Accompanying the unconventional sexual fantasies experienced by persons with sexual deviations are intense erotic cravings. These cravings lead to a discomforting feeling when frustrated; a discomfort which can be relieved temporarily if deviant fantasies are enacted. Thus, the temptation to act can become difficult to resist. If a person experiences a strong desire to engage in illegal sexual involvements, there is considerable risk he may get into trouble repeatedly because his unconventional sexual drive keeps reoccurring. The paraphilic rapist who craves coercive sexual activities may repeatedly rape in spite of incarceration because punishment does little to reduce his intense unconventional sexual drive. Although many men can become sexually aroused by descriptions or scenes of coercive sexual acts, most do not have the constant ruminations that characterize a craving, and most do not have to resist repeatedly the temptation to rape in order to stay out of trouble. Groth reported that although about 25% of child molesters re-

ferred to his clinic were "first offenders" according to the law, first conviction rarely constituted the first such incident in the offender's life (3).

Rape, sexual involvement with children, public exposure of genitals, and "peeping" are behaviors, and in and of themselves do not allow one to make the diagnosis of a sexual deviation syndrome. Men with conventional sexual desires, for instance, may occasionally look through a window at a partially clad woman; an occasional incident of this sort does not make one a voyeur. However, when such behaviors are a reflection of ongoing sexual preoccupations and cravings to act repeatedly in those ways, a diagnosis of paraphilia can be made. Karl Jaspers described deviant sexual cravings as intolerable states, similar to addictions, that demand action in order to be alleviated (4).

Individual paraphilic syndromes tend to be relatively stable, just as is conventional heterosexuality. Voyeurs do not become transformed into pedophiles, transvestites or exhibitionists. Sexual behavior seems to be a relatively stereotyped response to one's erotic interests, and these appear to be relatively stable throughout an individual's adulthood.

Types of Treatment

Conventional heterosexuality can be conceptualized as a syndrome, comprising erotic thoughts, feelings, and associated behaviors, just as is exhibitionism or voyeurism. Thus, use of the term "treatment" involves making a value judgment. Some (e.g., NAMBLR—The National Association for Man-Boy Love Relationships) have argued that sexual involvement with children causes no harm, and should not be considered sick or bad. Most persons in our culture disagree. Those who do use the term "treatment" feel that it should become a consideration when one's sexual behaviors compromise the rights of well-being of others. Four general types of treatment have been proposed: psychotherapy, behavior therapy, surgery and medication.

Psychodynamic therapies usually assume that sexually deviant behaviors are the result of unconscious conflicts, and that "uncovering" these conflicts allows a person to better understand himself. However, it seems doubtful whether persons can really come to fully understand the basis of their own sexual interests. Eicher, for example, discovered that feelings of gender identity may be related to the presence or absence of H–Y antigen (5). In addition, understanding the etiology of one's sexual urges doesn't necessarily change them. There is little evidence that traditional psychotherapies are consistently effective in treating paraphilic syndromes.

Behavior therapies are less concerned with the historical antecedents of unconventional sexual behaviors than with the question of what can be done about them. A variety of techniques have been attempted. A common feature involves efforts to diminish the appeal of previously erotic deviant stimuli (such as children), while at the same time teaching an individual to become sexually aroused by a more appropriate partner, or sexually satisfied in a more appropriate way. This is clearly a formidable task, analogous to trying to teach a man with conventional heterosexual interests to become erotically attracted to boys. Most of the literature on behavioral treatment of sexual deviation consists of anecdotal case reports without proper controls. However, Marks was able to document good results at two-year follow-up with behavioral treatment of transvestites (men who dress in women's clothing for erotic pleasure), but he obtained poor results using the very same behavioral technique with transsexuals (men who feel themselves to be women trapped in the body of the wrong sex) (6). A recent review by Blair and Lanyon suggests that exhibitionism may sometimes respond well to a behavioral approach (7).

Two types of surgery, neurosurgery and orchidectomy, have been used to treat paraphiliacs, often when violent physical assault has been a significant component of the sexual syndrome. A recent article by Freund reviewed the literature dealing with the effects of such surgery on animals and humans (8). For humans undergoing neurosurgery to try to decrease deviant sexual desires the population size is too small to allow generalization of results, but in animals specific brain areas seem to be important contributors to sexual behavior. While castration is an unacceptable form of treatment in the United States, its use as an option to incarceration in other countries dramatically decreased the recidivism rate of deviant sexual acts (though not to zero), sometimes without causing total impotence (9).

Two medications used to treat sexual deviations are cyproterone acetate, which is unavailable in this country, and medroxyprogesterone acetate. Both decrease levels of serum testosterone. The intent is to try to decrease the intensity and frequency of sexual fantasies and preoccupations, making self-control easier. Neither drug acts specifically on deviant urges, but rather each appears to be a suppressant of sexual desire in general. Counseling is ordinarily given in conjunction with medication to help the patient cope with difficulties resulting from his deviant sexual needs.

Associated Biological and Characterological Pathologies: Questions of Etiology

Goy and McEwen, at a conference at The Massachusetts Institute of Technology, suggested that biological factors may contribute more than previously recognized to human sexual behavior (11). Recently, an entire issue of *Science* (Vol. 211, No. 4488) addressed this topic, as well as related issues. Biological factors in animals significantly influence sexually related activities. In some species of birds, normally only males sing, but if a female zebra finch that has been administered estradiol while just an embryo is given androgen hormones as an adult, she will do so also, and will have an increased number of cells in the nucleus robustus archistraitalis and other brain areas (12). She will also display distinctly male courtship behavior. Adult female rats who were exposed to testosterone at a specific time *in utero* will show sexual mounting behavior that normally predominates in male rats (13). In humans, there is evidence that some women initiate sexual activity most often during the ovulatory period of the menstrual cycle (14). Because sexual behavior is so intimately related to

biology and species preservation, as well as to psychological and experiential factors, it is reasonable to look for organic pathologies in men experiencing unconventional sexual cravings.

Table I lists associated pathologies found in a group of 22 consecutively assessed paraphilic patients. Most were referred to Hopkins by their attorneys, or by the courts, though a few were self-referred. Eighteen of the twenty-two evidenced a variety of abnormalities that included structural brain damage, elevated testosterone levels, genetic anomalies, seizure disorders, and pituitary hormone dysfunctions. As a safeguard against selection bias, appropriate control group data are needed for comparison purposes, especially regarding the variance of testosterone levels in "normal" men. "Normal" laboratory values of testosterone are based on small sample sizes, and conceivably could be in error. However, it is clear that many sex offenders seen here at Hopkins have evidenced significant organic pathology. This finding makes plausible the hypothesis that biological vulnerabilities in some individuals may predispose them to develop unconventional sexual desires (15). As the data presented are preliminary this is only a hypothesis, and further research is planned.

Factors contributing to the development of normal, as well as unconventional, sexual desires are poorly understood. In addition to the possible role of biogenic elements, there is evidence that particular sorts of early life experiences (e.g., being a victim of child abuse), may also sometimes be relevant (16). Many pedophiles have been sexually molested themselves as children (3).

Expression of sexual desire can be influenced by many aspects of a person's character. Thus, whether a pedophile is physically assaultive toward children may depend not only upon his sexual feelings, but also upon whether he is assaultive in general. There is no evidence that persons with deviant sexual cravings are more assaultive (except for paraphilic sadists and rapists) than persons with more conventional orientations. A study in Detroit of over 1,252 sex offenses against children, for

TABLE I

Associated Findings in 22 Consecutively Referred Male Patients with Sexual Disorders

Patient	Diagnosis	Associated Findings	
1	Exhibitionism	Elevated testosterone: 912 ng/ml	History of head injury in auto accident; grand mal seizures
2	Homosexual pedophilia	905 ng/ml	
3	Heterosexual pedophilia	1263 ng/ml	Mild ventriculomegaly. Cortical atrophy most pronounced in area of right sylvian fissure. 24 hour urine pregnanetriol = 3.1 ng
4	Raptophilia	916 ng/ml	Grand mal seizures
5	Homosexual pedophilia	1230 ng/ml	
6	Hypersexuality	880 ng/ml	Family history of adrenogenital syndrome
7	Voyeurism	Elevated LH: 98 ng/ml	
8	Homosexual pedophilia	77 ng/ml	Generalized muscular hypotonia
9	Homosexual pedophilia	Cortical atrophy (on CAT scan, secondary to auto accident)	Grand mal seizures, recurrent slow delta waves and sharp activity over frontal anterior regions (more pronounced on right)
10	Hypersexuality		Cortical blindness, mild mental retardation
11	Homosexual pedophilia		Cortical blindness
12	Heterosexual pedophilia		Visual spatial defects. Right sided partial hemiparesis of upper extremity with spasm
13	Homosexual pedophilia	Dyslexia	
14	Homosexual pedophilia	Dyslexia	Childhood lisp requiring speech therapy
15	Homosexual pedophilia	Childhood learning disorder	Strabismus
16	Homosexual pedophilia	Kleinfelter's syndrome	90% mosaic (previously undiagnosed). Elevated FSH and LH
17	Sexual sadism	Basal ganglion dysfunction	Oculomotor abnormality. Gait disturbance
18	Homosexual pedophilia	Schizophrenia	
19	Homosexual pedophilia	No abnormalities detected	
20	Voyeurism		
21	Voyeurism		
22	Homosexual pedophilia		

Testosterone was considered elevated if blood levels were more than 2 standard deviations above the mean (mean = 575 ± 150 SD). Ordinarily 2.5% of men would be expected to have such an elevation; in this sample 27% (6 of 22) had elevations. Normal 24-hour urine pregnanetriol = <2.5 ng.

example, found that the great majority did not result in physical injury (3). Although outdated psychiatric classification schemes listed sexual deviation as a form of sociopathy, persons with unconventional sexual desires may show no other evidence of antisocial character traits.

Pharmacological Treatment With Medroxyprogesterone Acetate

Medroxyprogesterone acetate can be injected intramuscularly, usually weekly, frequently at an initial dosage of 500 mg. It is then slowly absorbed into the blood stream and carried to receptor sites, reducing circulating levels of testosterone by decreasing testicular output. It does not appear to affect testosterone production by the adrenal gland, but does prevent the compensatory elevation of follicle-stimulating hormone (FSH) and LH ordinarily expected as a response to decreased testicular output. Dosage can be titrated to obviate total impotence, and the medication is not feminizing. Major side effects are weight gain and mild lethargy, but cold sweats, nightmares, myalgia, dyspnea, hyperglycemia, azospermia, hypertension, and breast cancer (in dogs) have all been reported. Most effects seem fully reversible when medication is discontinued, although long-term follow-up in excess of ten years has not yet been possible. The 100 mg/ml concentration has greater bioavailability and is less painful than the 400 mg/ml solution. No more than 250 mg should be administered into a single injection site.

A number of carefully documented studies conducted by Dr. John Money suggest that administration of this drug decreases the frequency of erotic imagery and the intensity of erotic cravings, as well as the frequency of erection and masturbation (17). Following treatment, a number of paraphilic patients have stopped deviant behavior entirely, reporting relief from pressure to enact troublesome sexual urges, while still maintaining the capacity for intercourse.

Table II summarizes changes in sexual behavior in 20 chronic paraphilic patients treated with medroxyprogesterone acetate. These data suggest that the drug can be helpful in a high proportion of cases, provided the patient is compliant in taking it. Compliance may depend partially upon the nature and intensity of the deviant cravings themselves, and also upon other aspects of a person's character and behavior such as his tendency to abuse alcohol, his capacity to form affectionate relationships, his temperament, and his attitude about treatment. Certain syndromes such as pedophilia may be more or less difficult to treat than others such as exhibitionism.

When patients stop taking the medication, their hunger for deviant sexual activities seems to return, putting them at risk of again engaging in behaviors which satisfy that hunger. Thus, the treatment seems to work by suppressing sexual appetite, rather than by acting as a temporary catalyst until psychological counseling can become effective. Although psychological counseling may not diminish erotic cravings, some patients report that it does help them in their efforts to establish a more appropriate sexual pattern. Brief psychiatric hospitalization for three or four weeks at the beginning of treatment may aid subsequent compliance.

Future Research

Medroxyprogesterone acetate has not yet been subjected to a double-blind clinical trial. This should be done, possibly using intramuscular injections of fluphenazine decanoate (a medication with similar side effects that does not reduce testosterone) as a pharmacologically active control. This should provide additional information regarding the effects of testosterone levels upon sexual feelings and thoughts.

Further advances toward understanding the relationship between biology and sexual experience should come about as a result of development of the positron emission scanner (PET scanner). Rather than showing brain structure, this device provides a picture which varies in color depending upon the rate of metabolic activity in various brain areas. It will be informative to learn what regions of the brain are metabolically active during sexual arousal; whether these areas differ in persons experiencing unconventional sexual desires; and what the effects of treatment with medroxyprogesterone acetate are upon brain activity.

Only by learning more about what motivates "sex offenders" will it be possible to find out how to prevent voyeurism and other improper sexual acts. Present approaches, including incarceration, have not proven helpful, and it is important to meet the need that exists within the community to deal effectively with these kinds of problems. It is hoped that the Hopkins program for studying and treating these conditions will continue to prove useful. Treating such patients can present difficulties because of stigma and prejudice sometimes directed toward persons and institutions doing so, but it is clear that many of these people, such as the patient under discussion, legitimately need and deserve help. More than 50 centers in the United States treat such patients (18).

Medicolegal Issues

The topic of sexual deviation and its treatment raises a number of medicolegal and ethical concerns. In a recent editorial in *The American Journal of Psychiatry* Seymour Halleck questioned whether a person facing incarceration can provide truly voluntary consent to receive treatment, knowing that refusal will lead to imprisonment (19). Admittedly, such decisions can be difficult. However, a person does not lose the capacity to choose just because a decision is difficult. Cancer patients sometimes have to choose between taking unpleasant chemical agents or dying. Furthermore, there is legal precedent for requiring individuals to take medication (e.g., measles vaccine), when not doing so threatens the well-being of others. Were persons incarcerated, or facing incarceration, to be denied access to antiandrogenic medications, based upon the idea that they are incapable

TABLE II

Changes in Sexually Deviant Behaviors in 20 Chronic Paraphilic Male Patients Treated With Medroxyprogesterone Acetate*

Patient	Diagnosis	Average frequency of sexually deviant behaviors before treatment†	Length of drug treatment‡	Occurrence of Deviant Behaviors	
				During treatment	After treatment
1	Homosexual pedophilia	once/week	5 years, 9 months	None	No relapse
2	Homosexual pedophilia	twice/month 1 known arrest	1 year	None	Relapsed
3	Heterosexual exhibitionism	2 times/week	10 months	None	Relapsed
4	Homosexual masochism	4 times/week	3 months	None	Relapsed
5	Bisexual pedophilia	2 times/week	3 months	None	Relapsed
6	Transvestism homosexual incest	7 times/week 2 known incidents	1 year, 4 months	None	Relapsed
7	Heterosexual sadism	once every 2 weeks for 25 years	3 years, 5 months	None	Still in treatment
8	Homosexual pedophilia	2 times/week 6 arrests in 6 years	10 months	None	Relapsed
9	Homosexual pedophilia	Once every 2 months 4 arrests in 6 years	2 years	None	Still in treatment
10	Homosexual pedophilia	once/week 14 arrests in 29 years	3 years, 9 months	Relapsed	Treatment continues
11	Homosexual pedophilia	2 times/week 7 known arrests	4 years, 2 months	None	Still in treatment
12	Voyeurism heterosexual pedophilia	2 times/week (pedophilia) 5–8 arrests	5 years, 3 months	None	Relapsed
13	Homosexual pedophilia	2 times/week since age 10	5 years, 9 months	None	No relapse
14	Homosexual pedophilia	once/month numerous arrests, 4 convictions, 4 parole violations	3 years, 8 months	Relapsed	Treatment continues
15	Homosexual pedophilia, exhibitionism	probably several incidents/year	3 years, 9 months	None	No relapse
16	Homosexual pedophilia	once/week	1 year, 1 month	None	Relapsed
17	Heterosexual voyeurism	once/month	1 year	Relapsed (while intoxicated)	Treatment continues (in prison)
18	Heterosexual exhibitionism	5 times/day since age 11 numerous arrests	2 years, 2 months	None	Relapsed
19	Heterosexual exhibitionism	2 times/week	2 years, 1 month	None	Relapsed
20	Heterosexual exhibitionism	4 times/week binges of 20/day	2 years, 3 months	None	Still in treatment

Adapted from Reference 10.

* Deviant behavior was considered to have occurred if the patient was accused of having it, or admitted to it, even if it did not come to the attention of the law.

† Based on institutional records and patients' statements.

‡ Patients who stopped medication did so against advice, except in the cases of patients 13 and 15.

of voluntary consent, it is likely that civil libertarians would protest. It can be argued that administering medication to a willing convicted person (even as part of an investigative study, provided it may directly benefit him) is very different from using him to study the effects of a drug (e.g., rabies vaccine) unrelated to his potential benefit.

Another medicolegal issue raised in considering the matter of sexual deviation relates to the concept of "free will," a concept whose meaning has been pondered by philosophers for centuries. Society, through its laws, needs to hold individuals accountable for their own behavior. Some persons are able to control their sexual behavior without help, but persons are likely to differ in the intensity and quality of their erotic desires. Many paraphilic men, prior to treatment with medication, report that their desires are so intense that they are unable to resist temptation successfully. Many of the same men report that their desires become sufficiently diminished while taking medication that they are able to stop deviant activity (and they do). Some state that while taking medication they feel for the first time that they have a choice about whether or not to act. There are other psychiatric syndromes as well (e.g., compulsive handwashing) in which, prior to treatment, persons seem to lack the capacity to stop certain behaviors on their own. Such data clearly present difficult legal and ethical dilemmas.

The psychiatric literature is sometimes misleading in guiding the law about the topic of sexual deviation. Many psychiatric texts, for example, state that rape is

not a sexually motivated crime, but rather an act of anger and hostility directed toward women. While it is true that some rapists have hostile motives, and that some suffer from sexual dysfunctions such as premature ejaculation, the motivation to rape can be sexual rather than hostile. Furthermore, to argue that rape is not at least partially a sexually motivated act makes little sense when a man has obtained an erection and forces intercourse. The following verbatim excerpts from letters written by a convicted paraphilic rapist document that rape is sometimes very much a sexually motivated act (which is not to suggest that rape is nonassaultive).

> Sir, I am 32 years old and in the penitentiary for several rapes. All my life I've felt I wasn't normal ... being the sex maniac I've been ... messed up in sexual thought and behavior for God only knows how long. Since I was 4 or 5 years old, sex has been 90% of my thoughts. After I was married I would have sex with my wife every night, then I would go masturbate. Sex was all I could think of. The rapes started when I [saw] a naked woman through a window. Since that time it's been 8 or 10, maybe more. The only way to stop the thoughts was to have sex or ejaculate. Sometimes I masturbated. After (each rape) I felt ashamed. I tried to stop and could for a month or longer, but ended up doing it again. It was as if I was being driven. I know it [doesn't] sound true or logical, but at a certain point, I could not control myself. The important thing to me now is getting relief from sexual thoughts. My wife said I could have come to her with this. How could I tell a woman I have something this bad? She never denied me sex. When I was arrested, I was so glad it was finally over. The only things against the law I've ever done is because of sex. I don't like to hurt people. Some people have told me I'm just a dirty person, and I did those things because I wanted to and enjoyed it. This is not true. Maybe I did want to in a way, subconsciously or something. But I did not enjoy being that kind of a person. I have cried and hated myself. At a certain point understanding fails me. I can't comprehend. What makes a person want to do these things?

Summary

Sexual deviation syndromes (paraphilias) are diagnosable psychiatric syndromes manifested by 1) recurrent persistent deviant fantasies, 2) intense erotic cravings that are noxious when frustrated, and 3) relatively stereotyped behaviors in the sense that exhibitionists expose themselves, whereas voyeurs "peep." These syndromes follow a predictable course, often respond to biological treatments, and may have associated organic pathologies, but their etiologies are poorly understood. Sexual offenses, as defined legally, may or may not be perpetrated by persons with one of these syndromes. When offending behavior is related to such a syndrome, medroxyprogesterone acetate may be helpful, provided the patient is compliant. It is not known whether this medication can help when such behavior is unrelated to deviant sexual cravings, as when rape is committed in response to anger and hostility—something which may occur more rarely than many psychiatric texts suggest. Legal demands for justice and safety as well as medical concerns for understanding care must both be considered, because each is important. When a person seeks help, as did the patient presented, his difficulties should be appreciated rather than scorned as perversions.

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