

### **P.S. By my article: Dutch psychiatrist Gerard Roelofs**

Recently, Psychiatrist Gerard Roelofs, The Netherlands, told his opinion – already known for years, in the Dutch Press. I translate this passage (in my Duchy English), to compare Roelof's opinion with the four criteria and the PS, mentioned in the my article above. As mentioned, these criteria above are developed in IPCE Meeting discussions and in NVSH Iwg JORis' meetings and Newsletters. Please, compare them with Roelof's opinion.

"Above the age of twelve, a sexual relationship with an adult is not nececarally harmful for a child. 'In that case it mutuality *can* be possible and the interest of the child *can* have prioity'.

"[Roelofs] has developed five criteria for a healthy pedophile relation. [1.] There should be no coercion; [2.]the child should be able to stop [te interaction] at every moment. [3.] At third, sexuality should be [only] at the psycho-sexual level of the child. In other words: the intimacy has to fit in the sexual feeling of the 12 to 16 year old youngster. 'One can think about mutual masturbation, but not about real hard sado-masochistic games,' says Roelofs.

"Two other conditions however, will in most cases form an obstacle for the actual generation of pedophiles: in Roelofs opinion, [4.] the parents of the child should know about the relationship [and the sexual aspect of it]. [5.] Also is a condition that the child can talk about the relationship in his [social] environment, *without* meeting disapproval.

[The P.S.:] "With these conditions, Roelof's opinion will be only a theory nowadays. No 'good parent' shall give permission for a sexual relationship of his or her child with an adult nowadays. Just so Roelofs himself, he has to confess. "But after twenty years one could find such parents."

(Dagblad De Limburger, 8 August 1998)

## **CHAPTER 6: SCIENCE-ORIENTED ARTICLES**

### **Paraphilias and Therapy**

by Agner Fog, Ph.D.

Nordisk Sexologi, vol. 10, no. 4, 1992, pp. 236-242.

#### **Introduction**

The understanding of non-procreative sexual behaviour has always been the toughest riddle in sexual science, and there are still more questions than answers. This has led to a criticism of the traditional paradigm in sexology and a search for new paradigms (1). Traditional sexology based on psychology and psychiatry tends to look at the individual only, and seek the causes of any problem in the life history of the individual. This I call the ontogenetic paradigm.

Social scientists, anthropologists and historians have argued that everything depends on the structure of the society - its norms, values, concepts, scripts, etc. Even the concept of sexuality itself is an arbitrary construct, which is only about 120 years old and does not have the same meaning in other cultures as in our own (2). Social construction theory, social cognition theory, social script theory, symbolic interactionism, semiotics of body communication, social identity theory, and the sociology of deviance, are new areas of research with promising potentials for explaining sexual behaviour as it is shaped by our culture. This sociogenetic paradigm has improved our understanding of homosexuality considerably during the last few decades, and in the future it will no doubt give valuable contributions to other areas of sexology as well.

The least explored area of research is the phylogenetic paradigm, comprising sociobiology and ethology. It explains general phenomena by the evolutionary history of the human species. It has been shown by ethologists that non-procreative sexual behaviour is common among non-human primates. Behaviours such as "homosexuality" and "paedophilia" are functional among apes, and probably among humans as well. When such behaviours occur among humans they may violate moral norms, but not biological laws (3).

The reason why paraphilias are difficult to understand in the traditional sexological paradigm is that this paradigm assumes that sexuality has only one ultimate biological function: procreation. The phylogenetic paradigm discloses, however, that sexuality has many functions, and the sociogenetic

paradigm tells us that many of these functions are suppressed in our culture but not in certain other cultures. The integration of all three paradigms is necessary for a full understanding.

It is evident that the choice of paradigm influences the scientific results. It also influences the way we look at puzzling phenomena. Take exhibitionism as an example. An ontogenetically oriented scientist would ask: "Why can't this man keep his pants on?" The sociologist would ask: "Why do people get scared and hysteric when they see a naked man?" And the phylogenetic scientist would discuss the function of visual sexual communication in the lives of our ancestors.

The present article discusses some of the problems encountered by sexually deviant persons and how these problems can be solved. Some common therapeutic techniques are criticized and alternative techniques are recommended. The main theoretical focus is on the sociogenetic paradigm.

### ***Isolated minority syndrome***

Let me introduce a new model which describes the situation of a person whose sexual peculiarities are suppressed by the surrounding society. This model I call the isolated minority syndrome.

The cause of this syndrome is a lack of identification model. The so called "pervert" has no knowledge of any appropriate script for the paraphilic behaviour that would satisfy him. He has no contact with experienced paraphiliacs who could teach him the most appropriate way to act out his wishes and the pitfalls to avoid. He does not even have an understanding of his own identity. And he tries to suppress his paraphilic fantasies because he does not accept them himself.

The symptoms are an extremely stereotypic, inflexible and un-controlled sexual behaviour that is hardly satisfying to himself and certainly not to his partner (if he has any). He repeats the same stereotypic fantasy over and over again with hardly any variation. He regards his partner as an object. He has very unrealistic ideas about the ideal partner that would satisfy him and he has no chance of finding a partner who would match these ideas.

The lack of identification model may lead him into a permanent search for information about his paraphilia. He reads anything from scientific literature to pornography. He collects anything that has a connection to his sexual object. If he is in therapy, he will most certainly try to get information from his therapist. He will read the therapist's model or script for paraphilic behaviour out of the questions the therapist asks. And he is likely to internalize the therapist's script for paraphilic behaviour. This means that he is likely to fulfil all the therapist's expectations concerning deviant behaviour. He will even talk the therapist's language. Any theory about the paraphilia that the therapist may come up with will be a self-fulfilling prophecy.

The social symptoms in the isolated minority syndrome can best be explained by the theory of deviancy amplification (4). One type of deviance leads to other deviances. The sexual frustration, low self-esteem, social stigmatization and isolation may often lead to substance abuse, social deroute, non-sexual crimes, political extremism and suicide.

The psychological defense mechanisms include suppression and repression of the deviant impulses, projection of the deviant impulses on other persons, and violence against the sexual object. The paraphiliac may even kill the sexual object (e.g. children) in a symbolic attempt to kill his deviant impulses.

A paraphiliac who has contact with similarly disposed persons and who accepts his own feelings does not show these symptoms. His sexual behaviour is more flexible and controlled by rational thinking. If for any reason he chooses not to have sex, he can refrain from that and still preserve his mental health and self-control despite the sexual frustrations.

The isolated minority syndrome may be seen in paedophiles, exhibitionists, bisexuals, sadomasochists, fetishists, transvestites, transsexuals, etc. The symptoms mentioned above are often believed to be characteristic of paraphilias per se, but they are in fact secondary symptoms of the social suppression (5). It is not possible to change the sexual orientation, but it is possible to cure the isolated minority syndrome, thereby improving the client's psychological and social well-being. The client will gain self-control which means that the uncontrolled, aggressive and perhaps dangerous sexual acts will be replaced by more harmless and well-controlled acts. The well-known metaphor of a steam-boiler illustrates the situation quite well. The libido is like the steam pressure that builds up and requires an outlet. Masturbation fantasies, pornography, and other substitutes function like a safety valve that will let out steam and relieve the pressure if the preferred outlet is not available. If, however, the person has internalized society's condemnation and tries to suppress not only the paraphilic behaviour but also the paraphilic fantasies, in other words: if he suffers from the isolated minority syndrome, then the safety valve is closed and the vessel will explode in an outburst of uncontrollable sexuality.

Traditional studies of paraphiliacs are based on psychiatric and forensic populations. The vast majority of these populations suffer from the isolated minority syndrome to various degrees. This has created an image in the psychiatric literature of paraphilias as uncontrollable and dangerous compulsions. Members of sexual minority organizations, however, suffer only slightly or not at all from the isolated minority syndrome and they do not match the image presented by psychiatrists. Sociological studies based on populations from sexual minority organizations give a totally different image (5).

### ***Treatment***

The best treatment for the isolated minority syndrome is obviously group therapy or self-help organizations. Experienced members of such groups can function as positive identification models for less experienced members with the same or a similar paraphilia, and teach them how to find a matching partner and how to live a sex life that is satisfying to both parties. The formation of such organizations for all common paraphilias should be encouraged and supported, and any person who suffers from the isolated minority syndrome should be encouraged to become a member of such organizations and subscribe to their publications.

The author has personal experience as volunteer counsellor in several sexual minority groups. I will describe the experience of a Danish exhibitionist group as an example.

The well-known flasher hates his own behaviour but cannot help it. He wants to exhibit himself only in front of unaccompanied strangers, not because he by nature prefers strange partners but because he is too ashamed to let anybody he knows see him in this highly embarrassing situation. This behaviour is not as satisfying as he could wish, because the strangers become annoyed or scared and do not want to look at him. And it is certainly not satisfying to his victims either. When we started the exhibitionist group the members soon began to strip naked in front of each other and after a few meetings everybody was naked most of the time and many were masturbating. They preferred total nakedness to just showing their sexual organs. They became more flexible, and several members gradually got the courage to experiment with alternative outlets such as nudist beaches, sex clubs, being nude models, etc. The limit between exhibitionism and voyeurism vanished as everybody enjoyed seeing as well as being seen. The limit between visual and physical contact also vanished. (However, touching had to be limited to steady partners because the female participants felt badly about it). A study of a similar group in Holland shows that the main effect of the group on the participants was to make their exhibitionism ego-syntonic. As a consequence of this, their exhibitionistic behaviour became less obsessive and egocentric, and more adjusted to the onlooker (6).

### ***Criticism of behaviour therapy***

The writing of the present article was provoked by LoPiccolo's recent article about treatment of paraphilias (7). I have to warn against the therapeutic methods described by LoPiccolo as they are ineffective as well as dangerous. The philosophy behind this behaviour therapy is limited to the ontogenetic paradigm, which is typical for American sexology. This paradigmatic limitation has prevented a full understanding of the paraphilias and led to an inappropriate therapeutic technique.

LoPiccolo admits that his therapeutic methods are not very effective. In fact they are less than that. Throughout the history of sexology numerous therapists have claimed their ability to cure paraphilias, but later investigations have always shown that the therapies were ineffective (8), and not infrequently the patients have fooled the therapists in order to escape further treatment (9).

Where my goal is to make the paraphilic feelings ego-syntonic to the clients, the traditional therapist wants to make them ego-dystonic. He demands that his patients suppress not only the paraphilic behaviour but also the paraphilic fantasies. The inevitable result is that the isolated minority syndrome grows worse. The safety valve is closed and the risk of uncontrolled outbursts of aggressive sexuality increases. This is why I find the behaviour therapy dangerous, not only to the patient but also to his sexual objects.

Occasionally I have had the difficult task of helping survivors of behaviour therapy. In these cases it has been obvious to me that the behaviour therapy has not only failed to accomplish its goal, it has also caused severe psychological trauma to the patient as illustrated in the following case:

Paedophile male, 53 years old, teacher, born in southern USA, very religious upbringing. Remembers loving boys as long back as before his school age. Arrested three times for being naked in the presence of boys. Forced by priest and lawyer to receive psychiatric treatment. Subjected to aversion therapy for 1.5 year. The therapy involved the application of a measuring apparatus on the patients penis and giving him an electric shock if he reacted to paraphilic stimuli.

Did you believe that you needed therapy?

- I believed that I needed to get out of the situation somehow.  
Did you expect it to work?

• Uh, probably not. At the time I was still sexually active with boys all through the therapy, so...  
Did the therapist know that?

- No.

Did the therapy affect your relationship to boys in some way?

• My sexual feelings for boys went away partially for about a year, and then at the end of the year I started waking up screaming and hollering with nightmares, and I would see a pitful of snakes and they were just everywhere and I would be screaming to get away from them. So I think this had to do with the phallic symbol and the fact that I was being messed up in my own sexual feelings and this came out as a fear of sex itself.

But not a fear of boys?

• I guess you could say that. The snakes were certainly crawling in my dreams, and when I'd wake up they'd go away, and then right after that I'd begin having my old feelings towards boys again.  
Did you have feelings for boys during the time you were in therapy?

• If you got into my feelings at the time, I was trying to prove to them that I was straight so that I would get through with the therapy. My whole goal was to get out of the thing, it wasn't to change anything.

Were you consciously trying to fake?

- I'm sure I was.

Were your feelings towards boys reduced by the therapy?

• They were reduced in the sense that my penis did not show the difference, but I still enjoyed being a teacher because I could be close to boys. I really don't think that feelings for boys or whoever we have feelings for has all that much to do with how much erection you have, but this is what they were reducing it to.

Do you still have bad dreams?

• I don't have the nightmares with the snakes very often, but once in a while I do. And I do have some recurring bad feelings that have just kind of flattened out all of life so that there are nebulous feelings that don't always relate to what they were meant to relate to. If I start to do a new job I might feel negative towards it, or if I go on a trip I might feel negative about it, but I think it has a lot to do with the insecurity, just the basic insecurity that was thrust upon me by that shock therapy. But rather than destroy my feelings towards boys they destroyed me as an individual, it destroyed my security.

### ***Ethical issues***

There are some basic ethical problems with this kind of therapy that need to be discussed. The first problem is the use of the psychiatrist to enforce social conformity. LoPiccolo does not mention homosexuality in his article in spite of the fact that homosexual acts are illegal in the state where LoPiccolo lives and that sodomy no doubt is the most common of all sexual crimes in the USA. There is no theoretical reason for not including homosexuality among the paraphilias; there is only the pragmatic reason that the gay organizations are politically strong. The very fact that LoPiccolo recommends the treatment of transvestites and fetishists but not homosexuals indicates that the normality criterion he enforces is indeed arbitrary.

The second problem is that aversion therapy may be regarded as torture. When prolonged physical punishment is used to suppress a non-dangerous behaviour such as fetishism, I would say that the ends do not justify the means. The physical pain may be severe, yet bearable, but the psychological pain is worse, as we have seen in the example above.

The third issue, and the one which involves the greatest ethical problems, is that of cognitive therapy. The rationale behind cognitive therapy is that the world view of the therapist is believed to be right and when the world view of the patient is different he is said to suffer from cognitive distortion. It is a basic doctrine in philosophy that there are no objective standards of truth. The patient may have a better knowledge of his own situation than the therapist, and the latter has no justification for saying that his perception is more true than that of the patient.

LoPiccolo discusses the treatment of "cognitive distortion" and gives as examples the fetishist who believes that he is merely sexually liberated and the paedophile who thinks that children can

consent to sex with an adult. The fetichist may indeed be sexually liberated, and the paedophile may have personal experiences that tell him that some children consent to sex because they enjoy it. The therapist refuses to believe this because he mistakes social and moral norms for scientific absolutes. Actually, he must have read the literature very selectively if he has overlooked the considerable amount of evidence that some children under some circumstances do enjoy sex with adults and deliberately seek such experiences (10,11,12).

Mind control is an abuse of psychiatry that should have disappeared with the fall of the communist regime in the Soviet Union, but paradoxically enough it still exists in a country that extols freedom and human rights. Cognitive therapy is brain washing. It is a violation of one of the most precious human rights: the right to think freely.

---

### **Abstract**

#### ***Paraphilias and Therapy by Agner Fog***

The traditional procreation oriented paradigm of sexology based on individual psychology prevents a full understanding of non-procreational sexual behaviour. In order to improve our understanding of the so-called paraphilias, the research must be supplemented by sociological and evolutionary biology paradigms.

A new model called the isolated minority syndrome is introduced in order to explain the behaviour of sexually deviant persons. The symptoms of this syndrome include a stereotypic and uncontrolled sexual behaviour and several unspecific social symptoms. The cause is a lack of appropriate identification model and non-acceptance of own sexual feelings. Group therapy in self-help groups is an effective treatment. There is reason to warn against traditional behaviour therapy which is ineffective, causes unnecessary psychological trauma, and increases the risk of violent sexual crimes. Traditional behaviour therapy is also criticized for ethical reasons.

---

### **References**

1. Sagarin E. Sex Research and Sociology: Retrospective and Prospective. In: Henslin J M, Sagarin E (eds.) *The Sociology of Sex*. New York: Schocken Books 1978.
2. Ussel J van. *Intimitaet*. Giessen: Focus, 1979.
3. Feierman J R (ed.) *Pedophilia: Biosocial Dimensions*. New York: Springer Verlag, 1990.
4. Young J. The role of the Police as Amplifiers of Deviancy, Negotiators of Reality and Translators of Fantasy. In: Cohen S (ed.) *Images of Deviance*. Middlesex: Penguin Books 1971.
5. Fog A. Klinisk bias ved forskning i seksuelle afvigelser. *Nordisk Sexologi* 1990; 8, 2: 163-167.
6. Klerk R de. *Het spel van kijken en bekeken worden*. Maastricht: Werkgroep S.i.R./Nat. Univ. Leiden, dissertation, 1990.
7. LoPiccolo J. Paraphilias. *Nordisk Sexologi* 1992; 10, 1: 1-14.
8. Hertoft P. Om falske homosexualitetsteoriers fatale konsekvenser 1869-1985. *Nordisk Sexologi* 1986; 4, 2: 50-62.
9. Conrad S R, Wincze J P. Orgasmic Reconditioning: A Controlled Study of its Effects upon the Sexual Arousal and Behavior of Adult Male Homosexuals. *Behavior Therapy* 1976; 7: 155.
10. Sandfort T. *The Sexual Aspect of Paedophile Relations*. Amsterdam: Spartacus, 1981.
11. Baumann M C. *Sexualitaet, Gewalt und psychische Folgen*. Wiesbaden: Bundeskriminalamt, 1983.
12. Li C K, West D J, Woodhouse T P. *Children's Sexual Encounters with Adults*. London: Duckworth, 1990.