Presentation of Paraphilias and Paraphilia-Related Disorders in Young Adults With Mental Retardation: Two Case Profiles

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Paraphilias are clinical disorders that encompass atypical sexual urges, fantasies, and behaviors, cause significant maladjustment, and frequently, involve criminal activity. Despite increased interest in the sexual functioning of people who have mental retardation, little is known about the presence of paraphilias among this population. This paper discusses diagnostic criteria and treatment considerations relative to paraphilias and paraphilia-related disorders, including two case profiles of young adults with mental retardation. These profiles highlight the clinical presentation of each adult and demonstrate differences in diagnostic screening and treatment formulation. Pertinent issues are discussed.

Keywords: developmental disabilities, intellectual, mental retardation, paraphilia, sexual deviance

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) defines paraphilias as “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one’s partner, or (3) children or other non-consenting persons, that occur over a period of at least six months” (p. 523). In some cases, the inducement of erotic arousal is dependent solely on the presence of paraphilic fantasies and stimuli. Other individuals rely on such stimulation periodically, (e.g., the paraphilia is dominant during episodes of extreme stress). The DSM-IV specifies that to qualify as a paraphilia, the presence of behaviors, urges, and imagery must cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (p. 523).

People who have a paraphilia are rarely self-referred but instead, become involved with mental health professionals when their behavior produces conflict with sexual partners or violates societal standards. Frequently, more than one paraphilia is present. Because paraphilias frequently occur with nonconsenting partners and can be physically injurious, forensic concerns can be prominent (e.g., criminal sex acts).

Paraphilias must be distinguished from nonpathological fantasies and behaviors that stimulate sexual excitement. According to the DSM-IV the characteristics that define a paraphilia are that: (1) it is obligatory for sexual arousal, (2) it leads to sexual dysfunction, (3) it involves nonconsenting individuals, (4) it has legal complications, and (5) it interferes with social relations, personal adjustment, and occupational functioning. The paraphilias listed in the DSM-IV include Exhibitionism (exposure of genitals), Fetishism (use of inanimate objects), Frotteurism (touching or rubbing against a nonconsenting person), Pedophilia (focus of prepubescent children), Sexual Sadism (inflicting humiliation or suffering), Transvestic Fetishism (cross-dressing), and Voyeurism (observing sexual activity). A category termed Paraphilia Not Otherwise Specified is reserved for conditions that do not meet the criteria for the preceding diagnoses. Disorders that fall into this category include sexual arousal and activity that involves making obscene phone calls (telephone scatology), animals (zoophilia), feces (coprophilia), enemas (klismaphilia), and corpses (necrophilia).

This article discusses the presentation of paraphilias and paraphilia-related disorders in two young adults with mental retardation (MR). Although there is increasing interest in the diagnosis and treatment of sexual deviance and sexually offending behavior in people who have developmental disabilities (DD), little has been written about the incidence of paraphilias in this population. The two profiles presented in this article highlight issues of diagnosis, risk assessment, case formulation, and clinical decision-making when considering the occurrence of paraphilias in people who have cognitive and intellectual challenges.
**Case Profile #1**

Mr. A was 34-years-old and had a full-scale IQ of 63 on the WAIS-R. He had attended several special education programs as a child and adolescent and generally, did not pose significant problems in those settings. When in his early 20’s, he gained employment in different vocational settings, working primarily at domestic and maintenance tasks. Throughout those years he lived at home with his mother. When he was approximately 24 years of age, Mr. A came to the attention of mental health specialists because he demonstrated episodes of agitation, “threatening” behavior, and periodic aggression. He was arrested in a garment store after he had been discovered trying on women's underwear and stockings. On another occasion, he disrobed at his work site. Mr. A’s mother reported that he had become “preoccupied” with thoughts about sexuality, finding a girlfriend, and getting married.

Staff that worked with Mr. A in several vocational training programs indicated that he expressed an interest in wearing women’s clothing and at times, carried a purse. Apparently, he spoke about being aroused sexually when dressed in pantyhose and similar clothing. He stated a desire to watch X-rated videos and to subscribe to the Playboy® channel. During this time period, Mr. A had moved out of his mother’s house and was living in a community-based, supervised group home with several other adults who had MR. It was reported that in this setting he had requested female staff to enter his bedroom while he was naked. He also spoke frequently about female staff as being his “girlfriends.”

In addition to his interest in sexual matters, Mr. A had a fascination about guns, war, and killing. He talked about obtaining a gun permit so that he could carry a firearm. Without the knowledge of the staff at his group home, he purchased a hunting knife that upon detection, was removed from his possession. The concern of Mr. A possibly committing a sexual assault led to several clinical evaluations to determine risk. One psychologist concluded that he had narcissistic personality disorder and a “vivid fantasy life” that was dominated by sexual themes. Mr. A was encouraged to seek individual psychotherapy with a male therapist, and staff at his group home were advised to discourage alcohol consumption and prohibit the viewing of sexually provocative movies. An additional recommendation was that Mr. A’s cross-dressing should be tolerated with the exception that he did not engage staff in this behavior (e.g., shopping with staff to purchase women’s clothing).

Approximately 1-1/2 years ago Mr. A was admitted to a psychiatric hospital due to “unmanageable” behavior in his home and aggression toward a psychiatrist who saw him on an outpatient basis. It was noted that he had not been taking his medication consistently (haloperidol, 20mg daily), continued to show a preference for firearms, and wore women’s apparel. His status upon admission to this program was described as “a potentially explosive psychotic man with sexualized and violent issues.” Shortly after discharge from the hospital, Mr. A was evaluated by a psychologist for a “risk assessment of dangerousness.” A precipitating factor to his problem behaviors at the group home was the curtailment by staff of him calling a “girlfriend” on the telephone. This person was a female peer he met at his work site. Staff reports were that Mr. A was “grandiose, entitled, and demanding.” He denied substance use and visual or auditory hallucinations to the evaluator but commented that he was in the military, had a license to own a gun, was a scout master in the Boy Scouts, and served as a Sargent in the Navy cadets. Mr. A also acknowledged that at one time he wanted to have a “sex change operation” but did not do so because his “girlfriend” wanted him to “be a man.” When questioned about his cross-dressing, he revealed that he was more comfortable wearing women’s clothing. He stated that he had not had sexual intercourse and that he did not have homosexual desires.

With regard to the objectives of risk assessment, the evaluator concluded that the most controlling influence to reduce risk was the continuous supervision that was provided Mr. A, his non-access to weapons, and the fact that there was little availability of potential victims. It was recommended that he continue to receive medication to control psychosis, that he work with a therapist who was well versed on issues of sexuality in persons with DD, that a behavior support plan be designed that focused on conditions that appeared to provoke challenging behaviors, and that access to pornographic material be limited to media that did not contain violent themes. Mr. A received diagnoses of delusional disorder (erotomania and grandiose types), exhibitionism, transvestic fetishism with gender dysphoria, major depression (severe with
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psychotic features), and narcissistic personality disorder with paranoid and antisocial traits.

Mr. A was referred to a partial hospitalization program for adults with DD, and his status upon admission to this program was described as “a potentially explosive psychotic man with sexualized and violent issues.” At the time of this writing, Mr. A continues to reside in a community-based group home and attend the partial hospitalization program.

**Case Profile #2**

Mr. B was a 24-year-old who had a full scale IQ of 69 (WAIS-R) and a diagnosis of mild MR. When he was 18 years of age and attending a vocational training program at a local high school, he was brought to the attention of school personnel concerning incidents of “touching female students inappropriately.” He was also referred for psychiatric evaluation because of “alleged sexual involvement with a dog” and indecent exposure. Mr. B eventually was admitted to a residential school for children and adults with DD. Several incidents of touching female staff at the school were documented in addition to an “attempt to engage in sexual behavior with a pet cat.” While in that setting he was seen by a forensic psychologist to address these concerns. It was concluded that he presented with “significant issues regarding sexual behavior,” although it did not reach a level that was aggressive or dangerous.

Mr. B was discharged from the residential school when he was 21 and returned to live with his family. Discharge reports commented that while at the school, he had many incidents of using sexually provocative language and gestures. Also identified was a concern about his fluctuations in mood and apparent depressive symptomatology. It was recommended that he receive close supervision in any habilitation setting that he might attend in the future.

While living at home, Mr. B entered a job-skills training program that featured employment support in a variety of community settings. By all accounts he demonstrated exemplary work, was conscientious, and cooperated well with peers. He participated in outpatient counseling to help him cope better with “impulsive” behavior and a tendency to “blame others” for his problematic behaviors. Relative to this latter theme, he denied having engaged in previous incidents of indecent exposure and contact with animals, stating instead that another person had committed these acts while wearing his clothing. Mr. B emphasized that he was attracted only to women but had never experienced intercourse or had a consenting relationship with a female peer. He drank beer occasionally but never used drugs.

Approximately one year ago Mr. B was accused of inappropriately touching a female van driver. He admitted that this event occurred but stipulated that it was an “accident” that happened when the driver moved in close proximity to him. This incident appeared to be the only occasion of “inappropriate sexual behavior” exhibited by him during the preceding three years. In response to this incident, Mr. B was referred to a clinical psychologist to evaluate his status and to provide therapeutic recommendations. This evaluation ruled out paraphilia as a diagnosis but emphasized the belief that Mr. B was at risk for engaging in offending behavior because he was highly susceptible to provocation by others and continued to demonstrate poor decision making when experiencing stress. The conclusion was that he be supervised closely within work settings and related community contexts to ensure that “triggering” conditions were prevented. Also, it was suggested that Mr. B be seen for individual therapy that incorporated a cognitive-behavioral orientation. The objectives of therapy were seen as teaching him meaningful heterosocial and self-monitoring skills.

At the time of this writing, Mr. B has been working successfully in a community-based vocational program and living with his parents. He receives counseling on a weekly basis and several behavioral supports have been introduced to reduce the possibility that offending behavior will occur. He has not engaged further in the types of critical incidents described previously.

**Discussion**

These profiles highlight the complexity in understanding and diagnosing paraphilic disorders in people with MR. On one hand, both Mr. A and Mr. B presented with several similar characteristics. First, their problem behaviors (cross-dressing, touching females, indecent exposure, sexual contact with animals) produced court-ordered evaluations and treatment considerations. Therefore, as is common with many people who have paraphilias, contact with the legal system was encountered. Second, both individuals were considered to be at risk for offending behavior and for that reason, received close supervision and monitoring within
residential settings. Mr. A’s clinical presentation was particularly problematic in this regard because of his preoccupation with firearms, weapons, and war related themes. A third common feature with both individuals, and one that is critically important from a therapeutic perspective, is that they had not experienced a consenting sexual relationship with another person. Therefore, the concerns about the inappropriateness of their sexual behavior and possible criminal activity (e.g., physical coercion and assault) must be considered in light of the facts that they had an absence of normal sexual outlets, deficient heterosocial skills, and limited knowledge of sexual functioning.

Important diagnostic distinctions emerged in the profile descriptions of these two adults. Mr. A, for example, received a diagnosis of transvestic fetishism, which has the defining characteristic of sexual arousal that is produced from the act of cross-dressing. However, the degree of sexual satisfaction he derived from wearing women’s clothing was unclear. Also, by all accounts, Mr. A did not engage in sexual activity that involved specific articles of clothing, a condition that would qualify as fetishism. His interest in pornography might be termed more appropriately a “paraphilia-related disorder” but similarly, is difficult to categorize because corresponding sexual behavior was not specified (e.g., masturbation when viewing pornographic materials, self-report of accessing pornography as a “compulsion”). Finally, Mr. A’s reports of having “girlfriends” and making persistent telephone calls to them was characteristic of erotomania but in other ways, did not adhere uniformly to the diagnostic criteria for this disorder in people with DD.

Mr. B’s behaviors of engaging in sexual contact with animals, indecent exposure, and touching females did not meet the diagnostic threshold for paraphilias because they were not evident over a period of at least six months and did not present as “recurrent, intense, sexually arousing” fantasies, urges, or acts. The concern that Mr. B was at risk for engaging in these behaviors despite their relatively low frequency appearance was voiced by several evaluators. However, a significant finding that dominated Mr. B’s history was that he was easily provoked into performing such acts by peers. For example, several of the aforementioned episodes were described as the outcome of “taunts” and verbal “dares” from other students. Therefore, in contrast to a pattern of predatory behavior, high rate sexual activity, and persistent sexual arousal, Mr. B’s clinical condition more definitively could be linked to specific interpersonal encounters which, when absent, made it less likely that sexually inappropriate activity would occur.

With reference to the differential diagnosis of paraphilias, the DSM-IV states that for people with MR (and other conditions such as dementia, manic episode, and schizophrenia), “there may be a decrease in judgement, social skills, or impulse control that, in rare instances, leads to unusual sexual behavior” (p.525). These influences can be distinguished from a paraphilia “by the fact that the unusual sexual behavior is not the individual’s preferred or obligatory pattern” and “the unusual sexual acts tend to be isolated rather than recurrent and usually have a later age of onset” (p. 525). As such, in considering sexually deviant behaviors (paraphilias) in people who have MR or related disabilities, misdiagnosis can occur when an evaluator fails to address the impact of learning history, cognitive deficits, and social skills development on symptomatology. The term “counterfeit deviance,” for example, refers to behavior that is topographically deviant but is provoked and maintained by other factors. Possible influences related to “deviant” sexual behavior may be a person’s (1) lack of information about sexual expression, (2) victimization, (3) poor social and heterosocial skills, (4) deficits in assertiveness, and (5) limited opportunities to establish appropriate peer relationships. Mr. B’s profile, in particular, appears to be an example of “counterfeit deviance” and underscores the importance of identifying developmental learning influences and contextual determinants on sexual functioning of people who have DD.

The continuing study of paraphilias and paraphilia-related disorders among people with DD should address several areas. As revealed in these profiles, the diagnostic criteria set forth in the DSM-IV may not be applicable to individuals who have intellectual and cognitive challenges. The difficulty obtaining reliable self-report, the impact of social learning variables, and the restricted opportunities many people with disabilities face in establishing consenting sexual relationships with peers are some of the concerns that effect diagnostic clarity. The presence of a mood disorder, most notably depression, often is a comorbid diagnosis in individuals evaluated for paraphilias and likely has relevance for people with DD. Both Mr. A and Mr. B, for example, had a diagnosis of depression indicated in their
evaluation histories. Lastly, the identification of interventions to prevent the onset of paraphiliac disorders and to treat individuals who require therapeutic support remains a priority for professionals in the field of DD.

REFERENCES


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