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THREE CASES OF SEXUAL DEVIATION SEEN AT THE UNIVERSITY HOSPITAL, KUALA LUMPUR

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SUMMARY

Sexually deviant behaviour is a fairly common phenomenon but because it is socially embarassing, a few cases come forward for consultation and treatment on a voluntary basis. Most cases are referred by the law courts.

Two such cases, one of exhibitionism and the other of fetishism, were referred to the University Hospital, Kuala Lumpur in 1982. Their development histories were elaborated. A third case of sexual sadism came voluntarily for help out defaulted after the initial session. A review on the current western concepts on sexual deviation is included in the text.

It is concluded that although it is generally thought that neurological conditions give rise to deviant sexual behaviour, this assumption should not be arrived at hastily, as many cases of organic mental disorders do not exhibit deviant sexual behaviour.

INTRODUCTION

Sexual deviation disorders are usually classified under the sub-section of the paraphilias in the DSM-III. [1] The essential feature of this group of disorder is that unusual or bizarre imaginery or acts are necessary for sexual excitement. However, it must be stressed that sexual deviants are also capable of having normal sexual relationships.

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No accurate statistical data on the incidence of sexual deviation is available mainly because few patients seek treatment voluntarily. When a case is reported in the press, it attracts the attention of the public. Offenders are seldom apprehended but their acts can have far-reaching consequences on both themselves as well as on their victims, Most cases seen in the hospitals are referred by the law courts for either psychiatric opinion or treatment or both; few voluntary cases surface because of the social stigma involved.

In 1982, three such cases were seen at the University Hospital, Kuala Lumpur. One was a man who had been convicted for exhibitionism and was referred by his lawyer for treatment, while the other was referred by the Magistrate's Court for psychiatric opinion of his fetishism which resulted in his stealing of ladies' undergarments. The third patient came voluntarily for help to control his sadism. These three cases are described below.

Case 1

E., a 41-year-old Chinese, married welder was referred by his legal counsel, on 17 August 1982 for psychiatric treatment of his habit of exhibiting his genitalia to school-girls, which, in the opinion of his lawyer, was due to some mental defect of his client. E. had been treated for temporal lobe epilepsy by the University Hospital, Kuala Lumpur since 1978. An electro-encephalogram (E.E.G) carried out in 1978 was normal, despite clinical presentation of Jacksonian-type of epilepsy involving the right forearm and the right hand. However, despite treatment (Dilantin 200 mg daily), the fits persisted. On discharge, he was given outpatient treatment.

He was alleged to have exhibited his genitalia to

a group of school-girls on several occasions in the course of a week in 1981 while being seated in his car, parked outside the school compound at the time of his arrest. He denied the charges claiming that he was not at the scene of the crime on the days on which he was accused of having flashed to the girls. On the day of his arrest, he claimed that he was tuning the engine of his car which had broken down. At the time of his referral to the hospital, he was unaware that he had been punished with the penalty of a fine, insisting that the fine he had paid was actually the fee for the court procedure. However, his office colleagues thought that he was capable of having committed the offence.

E.'s development background was interesting. Born to poor parents who were vegetable-farmers and pig-rearers, he was the elder of two male children. When E. was eight-years-old, his father took a second wife despite no history of having marital discord with the first wife. At the age of eleven, he stayed with his father's second wife as his own mother had to leave to seek employment away from home. This lady often humiliated him with reference to his genitalia whenever she was angry with him (e.g. — "Let the chickens peck your penis off"). He described this lady as sexy. As a sixteen-year-old, he had his first sexual intercourse with a prostitute who chided him for his poor penile erection and premature ejaculation. A year later, another prostitute commented on his poor sexual performance and told him that his body was weak and that he looked like a girl. Being sensitive to such comments on his physical appearance, he took up weight-lifting exercises to build up his body. He also refrained from masturbation "to avoid becoming weak".

The first hint of his exhibitionistic behaviour was provided by a colleague of his, who said that E. had once told him that his (E.'s) favourite method of having sex was to masturbate himself and then show his erect penis to his sexual partner prior to peno-vaginal intercourse.

E. married a neighbour in 1977, through an arranged marriage. Although the existence of marital problems were denied, the couple had sexual intercourse only twice a month; this had decreased to once a month by 1979, the version given being that his physical illness had progressed in severity.

Interview with his wife and brother did not reveal any abnormal sexual or anti-social behaviour and he was said to be a kind and generous man. There was no family history of epilepsy or mental illness. Mental status and physical examinations of E. revealed no anormality. A psychiatric diagnosis of exhibitionism was made in addition to his focal epilepsy. He was maintained on Diazepam 5 mg tds and Dilantin 300 mg Nocte.

He was assessed by a clinical psychologist and the Wechsler Adult Intelligence Scale (WAIS) test indicated normal intelligence (IQ 96). However, the scores on the organic tests of Trails and Tactual Performance Test (TPT) indicated that he had bad right cerebral hemisphere dysfunction. A CT-Scan suggested a possibility of the existence of an AV-malformation in the right hemisphere. However, a repeat EEG showed no abnormality.

Despite treatment, E. developed fits in the ward. Psychiatric management of his evident behaviour was not carried out because he denied the existence of such behaviour. He was discharged and is still being followed-up by the psychiatrist and neurologist.

In this case, it was not possible to say that the patient's deviant behaviour was due to abnormal brain pathology, although this may be a contributory cause.

Case 2

Y., a 21-year-old Chinese, single, vegetable-seller was first referred by the local Magistrate's Court on 13 August 1982 for psychiatric assessment. He was accused of having stolen a lady's brassiere, a pair of stockings, a pair of lady's panties and a petticoat on 10 August 1983.

Y. admitted to having used ladies' undergarments to enhance his sexual pleasure during masturbation since the age of seventeen. He would wrap the undergarments around his penis as he masturbated.

His first episode started when he saw his sister-in-law's panties hanging on the clothes-line and out of curiosity, put the panties against his skin. Experiencing a pleasurable sensation, he proceeded to use it to masturbate by wrapping the undergarment around his penis. For the next two years, he stole his sister-in-law's undergarments and used them for masturbation. His family was not aware of his behaviour.

When Y. was nineteen, his brother and his sister-in-law shifted residence and the teenager resorted to stealing undergarments from other houses. The

undergarment were discarded after use on each occasion. Y. could still achieve sexual arousal without the undergarments but with their use, sexual arousal was achieved much faster and the orgasm was more intense. He did not derive any pleasure from new undergarments.

Y. came from a conservative and poor family and he was rather shy and introverted. He visited massage parlours and he could derive sexual pleasure from masturbation by the massage parlour girls.

Both the mental status and physical examination revealed no abnormality. He was diagnosed as having fetishism, and he was given outpatient cognitive aversion therapy which consisted of making him consciously aware of the possibility of being caught in the act of stealing undergarments again whenever such an urge arose. In addition, the technique of covert desensitisation [2] was used. He was taught to control the impulse of taking female undergarments by making himself rather uncomfortable, i.e. by pinching himself and holding his breath. He was also told that it was alright to masturbate by 'thinking' about female undergarments but not by using them; however, as soon as he attained erection, he should switch his imaginary away from undergarments. Here the line of management is on getting the patient to control his impulses. At the fourth month of follow-up, he had denied using undergarments for masturbation.

Case 3

P., a 31-year-old Chinese executive, came voluntarily on 9 April 1982 for treatment to control his sadistic behaviour of having to beat and inflict cigarette burns on his female co-habitee before he became sexually aroused for the past three years. The reason for his seeking the treatment was that this partner had threatened to leave him and to expose his dark secret if he carried on his deviant practice.

P. came from a middle-class, broad-minded family and he was a university graduate. There was no family history of mental illness nor was he treated for any significant physical or mental illness. He denied he had any early experience of hatred towards women.

P. said that he had his first exposure to deviant sexual behaviour while he was a student in London ten years ago. He used to frequent the infamous Soho district. He was introduced to sadomasochism by a prostitute. She was the passive partner and she asked him to beat her with a leather whip. He was sexually aroused when he saw the prostitute crying in pain and herself becoming sexually aroused.

When he returned to Malaysia six years ago, he had a girl-friend who was a rather passive person and allowed him to practice sadism on her. He promised to marry her. He belted her black and blue, and applied lighted cigarettes to burn her buttocks. While he was beating and burning her, his sexual arousal became greater and he would ejaculate without actual peno-vaginal intercourse. This girl left him after a year as he eventually did not want to marry her.

He said he felt lonely and dejected and had felt guilty whenever he went on dates with other girls. Normal sexual relationship did not satisfy him. He was often haunted by the thought that he was an 'abnormal monster' and he often wondered whether he would be able to find another partner for his abnormal sexual act.

He met the present cohabitee two years ago during a party and their relationship blossomed. His partner soon moved in to stay with him and he gradually introduced sado-masochism to her. She was not willing at first but he managed to convince her that he would not be happy and would not be able to release his 'pent-up daily frustrations' if he did not indulge in sadism. The partner gave in to this demands rather unwillingly and there were often quarrels over his frequent sexual demands.

A week prior to being seen, following a quarrel, his partner threatened to leave him unless he sought treatment to cure his vile behaviour.

Mental status and physical examinations revealed no abnormality. He was diagnosed as a case of sexual sadism with an underlying antisocial personality disorder. It was planned to treat him on an outpatient basis and he was told that he could get into trouble with the law; unfortunately, he defaulted his follow-up appointment and efforts to trace him failed.

DISCUSSION

The classical psychoanalytical view on sexual deviation is that it is either a fixation act or a regression to an earlier level of psychosexual development, resulting in a repetitive pattern of sexual behaviour that is not mature or genital in its application and expression, as described by Freud. [3] Castration anxiety is allegedly common in all sexual deviations and the sexual deviates is said

to utilise sex as a vehicle for the expression of other feelings such as hostility and anxiety, and either was regressed to or is fixated at an earlier level of psychosexual development. He is attempting to handle his anxieties regarding his sexual urges and his relationship with others, especially with the opposite sex. [4] Thus, we can understand why E. developed exhibitionistic traits — he appeared to have some aggression towards women.

However, the psychoanalytical approach does not appear to hold true when certain forms of sexual deviation such as fetishism and voyuerism, are encountered. In such cases, the learning or conditioning theory appears to offer an explanation for the phenomenon and it is indeed possible to condition sexual arousal to pictures of boots by associating them with pictures of nude women. [5] However, even the conditioning theory does not really provide a satisfactory model for the acquisition of clinical fetishisms. The quest continues for an answer to the question of why the true fetishist cares little about whether the fetish object is accompanied by a female in the flesh or why the real woman ceases to be sexually arousing after the fetishism has become established.

Wilson [5] put forward the concept of sexual deviation being the result of two major instinctual mechanisms, viz., the innate releasing mechanism and imprinting. The innate releasing mechanism refers to the inborn neural circuits which are stimulated by a range of potential sex-objects. This mechanism explains the ability of laboratory animals which have no upbringing by their parents, to be aroused by members of the opposite sex of the species e.g. the male chimpanzee's respond to the rear-side presentation signal of the female chimpanzee. Morris [6] discussed the likelihood of the visual configuration of paired pink hemispheres as represented by women's breasts and buttocks being an inmate sexual signal to the human male. Imprinting is the phenomenon of learning based on an individual's early environmental experiences such as the attachment of a kitten to its mother and the baby's cuddling of a teddy-bear as representation of security, love and warmth. At certain stages of the child's development, the range of stimuli which evoke sexual excitement is progressively delimited and specified. Imprinting adds details of the pattern for arousal to the already present innate mechanisms and this is to a certain extent, dependent on visual stimuli which are available in the environment. Pet owners have occasionally encountered sexual advances by their pets and this serves to illustrate the effect of both innate mechanisms and imprinting on the development of the sexual behaviour of the animal.

These mechanisms can 'go wrong' so that the sexual responses become attached to classes of stimuli other than the norm, that seem peculiar and socially unacceptable. When such mechanisms go wrong, deviant sexual behaviour results; for example, men who become sexually aroused by other men and domestic animals.

This view of the above mechanism 'going wrong' appears to be supported by the neurological findings found in association with deviant sexual behaviour in a number of cases. Epstein mentioned the relationship between fetishism, transverism and temporal lobe dysfunction, while Kolarsky, *et al.*, [8] mentioned a case of exhibitionism associated with head trauma during delivery. These two cases were supported by abnormal EEG findings.

Despite the above hypotheses, no hypothesis has been found to be satisfactory to explain all forms of sexual deviation.

In the case of E., he developed focal epilepsy prior to this alleged crime, although in the history he had shown a tendency to exhibit his genitalia to girls during sexual relationships prior to the onset of fits. His EEG was normal on two occasions although the CT-Scan did show an AV-malformation and he appeared to show a deterioration in his neurological status following the onset of fits. However, it must be stressed that although he had developed a neurological lesion prior to the alleged crime, it cannot be concluded that his deviant behaviour was due to the presence of an organic lesion. There are many cases of organic mental disorder who do not exhibit deviant sexual behaviour.

In the case of Y., it was unfortunate that an EEG was not done. However, he did not develop any syndrome of neurological basis and neither was any abnormal neurological findings detected on physical examination. Again, it cannot be concluded that he developed fetishism due to a neurological disorder.

The case of P. was not well worked-out because he had defaulted follow-up after the initial session. There was no positive neurological findings on physical examination.

When dealing with medico-legal cases, it is

important to remember that organic brain lesions do not necessarily cause deviant sexual behaviour.

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