Case Report

The Relevance of Drive and Relational Theories in the Context of Homosexuality and Masochism: A Case Study

Marty A. Cooper[1], Jamie L. Gordon[2]

[1] Assistant Professor, [2] Department of Psychology, SUNY Old Westbury, USA

Abstract

This paper discusses the use of psychodynamic approaches in the treatment of paraphilias. The paper will demonstrate the use of drive and relational structure theories as to the application to a psychotherapy case with a client in his 30's who is of mixed descent both Indian and White. The paper will review how both the drive and relational structures were utilized in the case, how it has impacted the treatment, and how it has impacted the life of the client. The outcome of the case resulted in a client who was better able to understand his relational patterns and how the paraphilia was related to his history. He reports being less disturbed by the fantasies and has also changed his behaviors. The paper will provide recommendations for clinicians considering a psychodynamic approach in the treatment of paraphilias.

Key words: Homosexuality, Masochism, Paraphilia, Psychodynamics, Psychotherapy

Date Received: 08th November 2019
Date Accepted: 28th December 2019

Correspondence should be directed to:
Marty A. Cooper,
Assistant Professor, SUNY Old Westbury,
Department of Psychology,
P.O. Box 210, Old Westbury,
NY 11568 USA
Email- cooperm@oldwestbury.edu

Introduction

According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) (American Psychiatric Association, 2013), a paraphilia can be defined as a *"...intense and persistent sexual interest in genital stimulation*

or preparatory fondling with phenotypically normal, physically mature, consenting human partners (p. 685)." This is differentiated from a paraphilic disorder which is a disorder defined as*"...currently causing distress or impairment to the individual...has entailed personal harm, or risk of harm, to others"* (American Psychiatric Association, 2013, p.685). Without arguing for the adequacy or appropriateness of these descriptions, we can see that the qualitative difference is not necessarily a difference of behavior itself but one of distress, impairment, or harm. This guides clinicians to differentiate between the expected variation of human sexual interest and that which is pathological.

A review of the literature will show that cognitive-behavioral therapy (CBT) and behavioral therapies, in general, dominate the available guidance for clinicians (Kaplan & Krueger, 2012; McManus, Hagreaves, Rainbow & Allison, 2013). Yet, literature shows conflicting results in efficacy regarding the utilization of CBT and behavioral therapies as a form of treatment for this population. For instance, Thoder and Cautilli (2011) and Edwards et al (2012) reported a decrease in paraphilic symptoms utilizing CBT. Meanwhile, both Kaplan and Krueger (2012) and Beech and Harkins (2012) report that the effectiveness of this treatment in the paraphilic population is extremely limited and lacks evidence. Not only are there conflicting findings, but also CBT and behavioral approaches focus mainly on symptom reduction and behavioral modification (Kaplan & Krueger, 2012). An alternative or adjunctive consideration to a cognitive-behavioral or behavioral approach would be an approach using the psychodynamic theories (Fong, 2006; Sadaat, 2014). Psychodynamic theories can help understand the etiology and maintenance of the paraphilia, along with exploring the shame, avoidance, anger, and impaired self-esteem and efficacy that are common in these individuals (Fong, 2006). Given the vast array of psychodynamic theories, it could be overwhelming for a clinician to determine how to determine which approach to utilize. According to Greenberg & Mitchell (1993), the psychodynamic landscape can be divided into two camps, drive structure, and relational structure models. Although it has been argued that this over-simplifies the

vast array of theoretical approaches (Gill, 1995), this article will work from this perspective for simplicity and to provide guidance to others looking to incorporate this into their work.

Case Conceptualization and Treatment

Identifying Data

The client entered therapy identifying as a gay, white, male. Though the client entered therapy identifying as such, his ethnic identity does vary depending on his mood state and his context. However, he has recently been considering how this identity vacillates and has been holding his Indian identity more consistently. Biologically he is half white (maternal side) and half Indian (paternal side). The client was born of a marital union and reports that both parents are alive and their marriage is intact. The client is in his latter 30's and resides on the east coast of the United States of America with his partner to whom he is married.

Developmental History

The client was raised on the west coast of the United States of America with his biological mother and father. In discussing developmental history, the client stated that developmental milestones were met within age expectations. In discussing his relationships within the family, he describes a distant relationship with his father and an enmeshed relationship with his mother. According to the client, his father was absent from home often due to being on work trips. On the other hand, the client reports that his mother was involved in most of the client's activities. Despite active involvement in his life, the client expressed that his mother encouraged his involvement in church, which endorsed homophobic ideologies that will contribute to the upcoming conceptualization of the client. Additionally, the client stated that his mother also endorsed negative attitudes toward Indian culture.

Contextual Variables

The client is currently employed as a manager in the field of customer relations. The client is a current homeowner in a major metropolitan area with his partner. According to the client, all basic needs are being met.

Cultural Factors

As previously mentioned, the client is both white and Indian, though the client discusses that he can often be white-passing. It was reported by the client that if people recognize that he is of mixed background, they do not assume that he is of Indian descent. Despite being of mixed background, the client was raised to largely deny his Indian heritage, which was encouraged by his mother. More specifically, the client states that he was 'raised white'. The client is currently married to a white male and is also in therapy with a white / native American psychologist.

Sexual History

The client reports having sex before the age of 18 years. He has been sexually active with men exclusively. Until recently, he reports having had intercourse with three men and has a history of long-term relationships. His first relationship, during college, started when he was still unsure of his sexual orientation. However, his more recent sexual history shows an increase in sex with strangers and one instance of hiring a sex worker. An additional complication was his devotion to his church and a discrepancy between the teachings of the church and his behavior. The client also states that he has a preference for 'dominant men'. Typically, these men are dominant physically but also hold power in other ways like finances.

Presenting Problem

The client originally presented to therapy for general symptoms of anxiety and depression, and difficulties in his marriage. These concerns have been part of the ongoing treatment plan. During treatment, the client presented with paraphilic fantasies, specifically with fantasies of sexual masochism. Though in the sessions the symptoms of anxiety and depression were addressed, for this journal, the client's presented problem of paraphilic fantasies will be the focus of this conceptualization.

Mental Status

The client denied episodes of depressed mood, diminished energy, loss of appetite, sleep disturbance, or suicidal ideation lasting two or more weeks. No periods of elated mood or hyperactivity lasting one week or more were reported. He denies thought broadcasting, thought

insertion, thought withdrawal, auditory distortions, and hallucinations, grandiose beliefs, persecutory beliefs, or feelings of being controlled. He had experienced more than four anxiety or panic attacks that were not situation-specific. The client had reported fear of certain social situations. He also admitted having had unwanted, repetitive thoughts. He denied having performed repetitive acts. His sleep pattern was characterized by somnambulism, waking up too early and having trouble falling back to sleep, awakening from nightmares, excessive daytime somnolence, and feeling unrefreshed by sleep.

The paraphilic fantasy is experienced by the client through frequent and disturbing masochistic fantasies that result in psychosocial difficulties. He reports that these fantasies interfere with his functioning such that he can become distracted in social and work settings. Additionally, the fantasies have been detrimental to his relationship and have negatively impacted his sex life with his partner. There was an escalation in the masochism when the client hired a professional sex worker to fulfill his masochistic desires. This moved the masochism from being primarily fantasy-based to impacting his behavior. The diagnosis of sexual masochism disorder meets the criteria for the DSM-5 (American Psychiatric Association, 2013).

The mental status was initially assessed through the completion of the Quickview Social History (Giannetti, 1983) and client report. Due to the dynamic nature of the treatment, the ongoing assessment was based on the client's report of symptoms. The client was seen for therapy once weekly for 44 sessions across 14 months.

Diagnosis

The client was diagnosed having 302.83 (F65.51) Sexual Masochism Disorder as per DSM-5 diagnostic criteria.

Drive Formulation

As previously stated, psychodynamic theories can help understand the etiology and maintenance of the paraphilia, along with exploring additional factors that may be present during the treatment of these individuals (Fong, 2006; Sadaat, 2014). Therefore, the treatment of the client involved

both the use of drive and relational approaches to therapy. With the superego acting as the moral belief system, using the drive perspective assumed that the client had an imbalance between his id and superego (Boag, 2014). On the other hand, the id is the unconscious that consists of the 'dark, inaccessible part of our personality', that is also the source of drives, impulses, and desires which serves as a starting point to understand the client's deepest desires about sexual masochism (Boag, 2014, Freud, 1933). Exploring this with the client revealed a rich internal world where he was able to live out a masochistic experience with a fantasy partner who is dominant and sadistic. The client speaks of this relationship as a place where he is controlled, dominated, and sexually submissive. However, he also speaks of tenderness in this relationship. He expressed fantasies of being 'tied up and used'; along with the desire to be told what to do. While exploring the id part of his ego structure, we also explored the superego to understand the rules that conflict with his desires. This ruleset was informed in large part by his religious upbringing, where he learned that being gay was a sin and unacceptable due to the church emphasizing the belief that sex was an act between a man and a woman. Due to this, he learned to hide his sexual orientation for many years, while living the first couple of decades of life believing and living as if being gay was bad. Additionally, his religious upbringing also impacted the client's views of masochism. Along with emphasizing that sex was an act between a man and a woman, the church also emphasized that sex was an act solely for procreation. Therefore, he viewed his masochistic behavior as immoral. Before therapy, the client was unable to find an ego compromise that would allow him to function without feeling the constant battle of the id and superego.

Drive Treatment

Through the process of therapy, the client was able to start questioning the rules in the superego and reestablishing a new set of rules that he chose for himself as opposed to those that were imposed on him. Additionally, he was able to fully explore his id impulses and desires and destigmatize them. This has allowed for a restructuring of what is an acceptable sexual

behavior. Before therapy, he would play these fantasies out in his head and eventually they became behaviors, which he later described in therapy how they would interfere with his functioning while keeping this therapeutic process a secret. Allowing himself to consider his masochistic desires as acceptable provided him the space to start exploring more sexual interests in his life in a more balanced way. The client found that in real life his paraphilic fantasies held less interest for him. This knowledge rendered the fantasies less useful and they have ameliorated across time.

Relational Formulation

Relational structure theory was also utilized in this treatment. As previously mentioned, the client presented with difficulties in his marriage, which through the therapeutic process the writer and client determined the relational structure conflict as the source of the difficulties. The relational structure conflict interfered with their sex life, created distance between him and his husband, and created a sense of isolation for the client. To repair these areas the therapist utilized a relational approach, which can be comprised of elements from several psychodynamic theories. The therapist relied primarily on object relations and interpersonal theories to inform the treatment. Object relations assisted the therapist and client to explore early relationships and how he learned to vacillate between object and person with primary male figures in his life. On the other hand, the interpersonal theory was utilized for the more pragmatic part of therapy and helped the client and therapist challenge the early object relations and develop new ways of relating.

Considering the client's object relations resulted in an understanding of his experience of men. As mentioned previously his father was fairly absent due to traveling for work, however, it should be noted that his father was emotionally unavailable as well. Related to this he internalized an anti-Indian bias from his mother; which impacted the way he saw Indian culture and ultimately how he saw his father and himself. Due to the absent father figure the client had been searching for a masculine object in his adult life. He describes the type of partner he is attracted to as

masculine, dominant, and confident, who can 'take control'. In some ways, it seems as though he was seeking some characteristics that were missing in his early life. Due to the drive conflict, spoken of earlier, he could not allow this relational structure to be realized. He would enter a relationship with the type of man that he desired but would find a way to ensure that the relationship failed. The mechanism he used was to ultimately find the flaw in the man he was dating and move from being dominated to the dominator. Utilizing traditional analytic language, he would castrate his partner. This process maintained unsatisfying relationships and led to more and more dependence on his paraphilic fantasies.

Relational Treatment

The client utilized therapy to understand this relational process, he was then able to consider that the very nature of the process would repeat itself until he considered other alternatives. The consideration of alternatives was complicated as his relationship with his husband was developed as consistently as his previous relationships. If the client were to consider an alternate way of relating, he would need to find a new way to be in his current relationship. Ultimately, he valued his relationship and determined that he wanted to find a new way to relate to his partner. This process involved his acute awareness of when he vacillated between object and person while relating to his partner. His awareness has allowed him to hold his partner as more of a person and less of an object across time. The client is continuing to work on this but has made meaningful shifts in his relationship resulting in feeling more connected with his partner. This has also resulted in less reliance on paraphilic fantasies and more engagement in reality.

Summary and Recommendations

Depending on the nature and severity of the paraphilia, psychodynamic approaches are a helpful approach to utilize or integrate into a treatment plan (Lothstein, 2019). By using psychodynamic approaches to evaluate past relationships, they help us answer the question of the etiology and maintenance of the paraphilia (Lothstein, 2019). For

instance, Lothstein (2019) states that the roots of the paraphilia can be traced back to the family, culture and the individual's experience as a child. The paraphilic behaviors are then maintained as they allow the individual to feel alive, contained and secure (Lothstein, 2019) while creating a false sense of confidence (Sadaat, 2014). Understanding the etiology and maintenance may help clinicians to understand the more pragmatic work that needs to be done. In this particular case an interpersonal approach was utilized for the pragmatic portion of treatment, yet integrating a cognitive behavioral approach at this point would have likely been effective as well and allowed for flexibility based on clinical experience and preference.

Before utilizing an approach like this there are some specific recommendations. First, clinicians would benefit from understanding how to work with psychodynamic approaches and how to differentiate between drive and relational approaches. As mentioned previously, Greenberg & Mitchell (1993) provide an in-depth look at this and may be a reasonable starting point for a clinician. Second, clinicians are advised to identify a qualified supervisor to guide them through this process. Third, assess the client to determine the appropriateness of fit for a dynamic approach. This may include assessing the client's ability to engage in insight-oriented work, client fragility, concrete versus abstract ability, etc.

Along with these recommendations, clinicians should be aware of the complexity of treating paraphilic disorders, along with the role that the clinician has on that treatment (Sadaat, 2014). Problems in treatment can occur if the clinician lacks understanding, empathy, and communication; thus clinicians working with paraphilic disorders may be well advised to explore their own biases (Sadaat, 2014). Understanding one's own biases is critical given that some behaviors can be seen as an expected variation of sexual expression or a paraphilia depending on several factors, including one's religious affiliation and cultural background (Bhugra, Popelyuk, & McMullen, 2010; McManus, Hargreaves, Rainbow & Alison, 2013). A lack of understanding bias may result in over pathologizing clients; which further emphasizes why clinicians

mustn't lack knowledge or attention to this disorder, and concurrent disorders (Sadaat, 2014). Therefore, part of this process may involve clinicians educating themselves about the broad range of sexual behaviors and understanding their reactions as they learn about these.

References

1. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). Washington, DC: Author.
2. Beech, AR., & Harkins L. (2012) DSM-IV paraphilia: Descriptions, demographics and treatment interventions. Aggression and Violent Behavior 17(6), 527-39.
3. Bhugra, D., Popelyuk, D., & McMullen, I. (2010). Paraphilias across cultures: Contexts and controversies. Journal of Sex Research, 47(2-3), 242-256.
4. Boag, S. (2014). Ego, drives, and the dynamics of internal objects. Frontiers in Psychology, 5(666), 1-13.
5. Edwards R., Whittaker MK., Beckett R., Bishopp D., & Bates A. (2012). Adolescents who have sexually harmed: An evaluation of a specialist treatment programme. Journal of Sex Aggression, 18, 91111.
6. Freud, S. (1933). New Introductory Lectures on Psycho-Analysis, The Standard Edition, Vol.XXII. London: Hogarth: W. W. Norton & Company.
7. Giannetti, R. A. (1983). Quickview Social History. Retrieved from http://search.ebscohost.com.proxy.library.nyu.edu/login.aspx?direct=true&db=mmt&AN=test.1569&site=edslive
8. Gill, M. (1995). Classical an relational psychoanalysis. Psychoanalytic Psychology, 12(1), 89-107.
9. Greenberg, J., & Mitchel, S. (1983). Object relations in psychoanalytic theory. Cambridge, MA: Harvard University Press.
10. Kaplan, M., & Krueger, R. (2012). Cognitive-behavioral treatment of the paraphilias. Israel Journal of Psychiatry and Related Sciences, 49(4), 291-296.
11. Lothstein, L. (2019). The rendering of the skin-ego and second skin: The formation of paraphilias as attempts to contain repair and transform the damaged self. Psychoanalytic Perspectives, 16, 48-69.
12. McManus, M., Hargreaves, P., Rainbow, L., & Alison, L. (2013). Paraphilias: Definition, diagnosis and treatment. F1000 Prime Reports, 5(36), 1-6.
13. Sadaat, SH. (2014). A review on paraphilias. International Journal of Medical Reviews, 1(4), 157-161.
14. Thoder VJ, Cautilli JD. (2011). An independent evaluation of mode deactivation therapy for juvenile offenders. International Journal of Behavioral Consultation and Therapy, 7, 40–45.