

ASSESSMENT AND TREATMENT OF PARAPHILIAS

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Current research on the assessment and treatment of sexual offenders has made it significantly more straightforward to design and implement Assessment battery and treatment programs for sexual offender in a variety of settings.

From a clinical perspective sexually inappropriate behaviour can be approached in one of two ways. Either the problematic features of the behaviour can be described or a clinical diagnosis can be applied (Marshall, Marshall, Serran, & Fernandez, 2006). The Diagnostic and Statistical Manual of Mental Disorders - text revision (DSM-IV-TR, 2000) lists the criteria used for diagnoses of sexual disorders relevant to sexual offending under the category of paraphilias. Paraphilias are described as recurring, intense, sexually arousing fantasies, sexual urges or behaviors generally involving nonhuman objects, the suffering or humiliation of oneself or one's partner, or children or other non-consenting persons that occur over a period of at least 6 months and causes clinically significant distress or impairment in social, occupational or other important areas of functioning. The paraphilias include: a) Exhibitionism (exposure of one's genitals to strangers), b) Fetishism (being involved with inanimate objects), c) Frotteurism (rubbing against or touching against a non-suspecting person), d) [Pedophilia](#) (sexual activity with a prepubescent child), e) Sexual Masochism (being humiliated, beaten, bound or otherwise made to suffer), f) Sexual sadism (sexual arousal from the psychological or physical suffering, including humiliation, of the victim), g) Transvestic Fetishism (use of fetishistic objects such as cross dressing with clothing belonging to the opposite sex), h) Voyeurism (peeping), and i) Paraphilia Not Otherwise Specified. This latter category includes some sexual crimes as well as other non-criminal sexual behaviours not included in earlier categories. Examples include, Telephone scatologia (obscene phone calls); [Necrophilia](#) (fantasies or actual physical sexual contact or sexual preference for a corpse rather than a living human); Partialism (exclusive focus on specific parts of the body); Zoophilia (sex with animals); Coprophilia (feces); Klismaphilia (enemas); and Urophilia (urine).

A sub-category of sexual masochism that has more recently been identified is "Hypoxiphilia, also known asphyxiophilia, or autoerotic or sexual asphyxia". In this case sexual arousal is produced while reducing the oxygen supply to the brain. The sexual urges intensify with the fantasy that the individual has died as a result of, or during, the practice (Hucker, 2006).

Sexual Sadism may include sexual arousal associated with killing, mutilation of corpses, injury to females, and the defilement of women. Mild Sexual Sadism includes activities such as consensual bondage and discipline, or dominance and submission in a specialized subculture. This may include role playing of dominant (punishing) and submissive (helplessness) roles, punishment and verbal degradation, use of gags and

blindfolds, forcing the submissive individual to behave like an animal and /or making him/her crawl, confinement to a cage, being forced to wear a diaper or lick the dominant's boots, binding or clamping breasts/nipples/penis, and urinating or defecating on the submissive and forcing ingestion. Major Sexual Sadism such as severe beatings, torture, burning, cutting, and rape-murder involves real injury or death to the victim. The element of fear in the victim and complete control of the victim is considered the major sexual stimuli.

While private and non-offending sexual behaviours such as cross dressing or fetishes are not considered criminal behaviours, sexual violence or assaults, child molestation or sexual activities in a non-consensual relationship are considered criminal offences (Hucker, 2006). Interestingly, the majority of sexual offenders are males and it is estimated that females account for only for 2% to 5 % of all sexual offences committed by Canadian offenders (Gordon & Nicholaichuk, 1996). Unfortunately, the DSM categories exclude many sexual offenders who clearly need treatment (e.g., rapists that do not have sexually sadistic offences and many child molesters who are not preferentially sexually attracted to prepubescent children). Marshall et al. (2006) notes that there is no evidence currently available suggesting that sexual offenders who meet the diagnostic criteria for a paraphilia suffer from more problems, have different etiological pathways to offending, or respond to treatment differently, than those who do not meet such criteria. Over the last decade there have been numerous criticisms of the DSM categories for paraphilias by those working with sexual offenders (Marshall et al., 2006) but this appears to have had little impact on the use of the DSM by professionals, particularly psychiatrists, working with sexual offenders.

In Canada individuals apprehended and convicted for sexual offences are typically involved in the penal system or sent to forensic wards for assessment and possible treatment. Assessment and treatment of male sexual offenders is often required for civil forensic settings and agencies involved with the Criminal Justice System such as court proceedings, admission and discharges from forensic and correctional, pre-post treatments testing.

Assessment of Sexual Offenders

Methods of conducting assessments include clinical interviews examining the individual's history (i.e., Psychiatric diagnosis, history of aggression, substance abuse), the use of general psychological and neuropsychological as well as psychophysiological measures such as phallometric testing, and physical examination and tests such as blood work.

a) Clinical Interviews

Clinical interviews with the offender can provide significant information about the offender's social and sexual history, attitudes, and skills. However, interviews with others such as spouse, parents, family members, friends, family physicians, and criminal justice personnel are encouraged in order to obtain useful collateral information and opportunities to verify self-report information from the offender.

(b) Psychometrics

A variety of pre-treatment psychometric tests relevant to treatment targets are typically administered prior to participation in a treatment program. These include assessments of sexual interests and psycho-sexual history; cognitive processes including cognitive distortions and empathy skills; social functioning; personality; substance use; and relapse related issues.

Current standards in assessment of sexual offenders promote basing risk assessments in statistically derived measures of risk (Ethical Standards and Principles for the Management of Sexual Abusers; Association for the Treatment of Sexual Abusers [ATSA, 2001]). Several risk/need measures used to evaluate the risk for general and violent recidivism of non-sexual offenders and specialized measures for sexual offenders have been found useful for the assessment of sexual offenders. These measures can also serve to identify need areas to be targeted during subsequent treatment programs. Examples of non-specialized measures that are generally used in Canada are the General Statistical Information on Recidivism (GSIR; Nuffield, 1982); the Psychopathy Checklist Revised (PCL-R; Hare, 2002); the Level of Service Inventory-Revised (LSI-R; Andrews & Bonta, 1995); Self-Appraisal Questionnaire (SAQ, Loza, 2005); and the Violent Risk Appraisal Guide (VRAG; Harris, Rice & Quinsey, 1993).

Measures specific to sexual offenders include: the Sex Offender Needs Assessment Rating (SONAR; Hanson & Harris, 2001); the Rapid Risk Assessment for Sexual Offenders (RRASOR; Hanson, 1997); the Static-99 (Hanson & Thornton, 2000); the Sexual Violence Risk – 20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997); and the Sexual Offender Risk Assessment Guide (SORAG; Rice & Harris, 1995). The SONAR (Hanson and Harris, 2001) is a 9 item scale designed to measure change in risk level for sexual offenders. It includes 5 stable factors (intimacy deficits, negative social influence, attitudes tolerant of sex offending, sexual self regulation, self-regulation) and 4 acute factors (substance abuse, negative mood, anger, victim access). The RRASOR (Hanson, 1997) was developed as a quick static actuarial tool for predicting risk of sexual recidivism. It contains only 4 readily available historical items, including history of past sexual offences, age at first offence, extra-familial victims, and male victims. The STATIC 99 (Hanson & Thornton, 1999) is an expansion of the RRASOR and includes ten items, some of which were adapted from the RRASOR. STATIC-99 factors include prior sexual offences, sentencing occasions, index non-sexual violence, prior non-sexual violence, male victims, unrelated victims, stranger victims, non-contact sexual offences, the age of the offender, and whether or not the offender has had a marital relationship. The SVR-20 (Boer, Hart, Kropp, & Webster, 1997) utilizes a structured professional judgment approach. It includes static and dynamic items within three domains: 1) psychosocial adjustment (11 items, e.g., sexual deviation, psychopathy, non-sexual criminal history); 2) sexual offences (7 items, e.g., minimization, attitudes, multiple sex offence types); 3) future plans (2 items, e.g., lacks realistic plans, negative attitude

toward intervention); and 'other considerations' not included in the existing 20 factors. The SORAG (Rice & Harris, 1995) is a derivative of the VRAG and has 14 static items. It has 4 variables not included in the VRAG that provide specificity to the sex offender population including, violent criminal history score, number of previous sexual offence convictions, history of sexual offences against female children only, and phallometric test results.

(c) Phallometric Assessment

Phallometric evaluation renders specific information regarding deviant sexual arousal/preferences. Slides are typically used as stimuli to determine age and gender preferences. The assessment of age gender preference involves using slides of nude individuals of both sexes across a variety of age groups. Seven categories are presented including neutral, male pre-pubescent, female pre-pubescent, male young pubescent, female young pubescent, adult male, and adult female. Interest in sexual violence relative to consensual sexual interactions is typically assessed using audiotapes and, less commonly, video. In the female sexual violence assessment responses to audio-taped descriptions of interactions between a man and a woman are monitored. Four categories are presented including neutral, consenting relationships, brutal rapes, and scenes of non-sexual violence. In the child molester assessment responses to audio-taped descriptions of interactions between a man and a male or female child are monitored. The five categories include neutral, passive victims, coercive sexual relationships, brutal rapes, and scenes of non-sexual violence.

The two major techniques for measuring penile tumescence are the volumetric and circumferential methods. The volumetric assessment of sexual arousal uses a tube-like device that encloses the entire penis and is sealed at the base of the penis by a cuff-like device. As the penis engorges during an erection air within the tube is displaced and measured to provide an estimate of the magnitude of penile erection. Circumferential approaches may use either a flexible metal gauge or a thin rubber tube filled with mercury or indium-gallium that operates as a strain gauge. A plethysmograph monitors conductance of electricity through the gauges, which decreases as the band expands or the rubber is stretched in response to increases in penile circumference. For both gauges, the output of the plethysmograph, a d.c. voltage proportional to the conductance of electricity, is monitored by a voltmeter. The metal-in-rubber strain gauge is somewhat less durable but is less expensive to purchase and is the more commonly used measurement apparatus for circumferential measures.

Phallometric results may be represented as raw scores in the form of either millimeter change in the circumference of the penis, voltage changes, or volume changes. Other scoring methods include transforming raw scores to either percentage of full erection or standard scores (z-scores). Transforming scores reduces intersubject variability due to penis size or responsiveness and allows for comparisons of responses both within and between subjects. Erectile responses may also be described by using indices of deviant arousal such as ratio and difference scores. Ratio scores are calculated by dividing the average (or peak) response to an inappropriate category (e.g., rape stimuli) by the average (or peak) response to an appropriate category (e.g., consenting sex). Difference scores are calculated by subtracting the average (or peak) response to an inappropriate category (e.g., prepubescent female) from the average (or peak) response to an appropriate category (e.g., adult female).

Problems with phallometry include a lack of standardization across sites, a lack of normative samples, and a dearth of research on the basic psychometric properties of phallometry. However, research has suggested that phallometric responses can differentiate between rapists and non-rapists and between some child molesters and non-offenders (Marshall & Fernandez, 2003). Additionally, sexual deviance, including deviance assessed using phallometry, has been identified as one of the strongest predictors of reoffence among sexual offenders (Hanson & Morton-Bourgon, 2004).

(d) Physical assessment

Organic treatments have also been utilized for controlling deviant sexual arousal in some sexual offenders. Such treatments may include hormonal medications such as antiandrogen medication, surgical castration, or stereotaxic neurosurgery. These treatments effect changes in the body's neuroendocrine systems by reducing the level of serum testosterone in the body, resulting in the reduction of sexual arousal (Bradford, 1985). However, they appear to be more appropriate for those sexual offenders for whom sexual motivation plays a significant role and not as a generalized treatment (Bradford, 1997). Problems associated with organic treatments include problems with patient compliance, side effects, and ethical issues related to performing irreversible procedures such as castration or stereotaxic surgery on patients.

Psychological Treatment

Early approaches to treating sexual offenders were often psychoanalytic in nature with a focus on helping the offender identify and resolve early life conflicts that were assumed to have triggered the offending behaviour. Psychodynamic techniques such as free association and dream analysis were utilized to address early traumas. However, evaluations of this approach to treatment have reported inadequate results (Crawford, 1981).

The development of behavioural approaches to treating sexual offenders marked a significant improvement but early programs were limited in scope. Behaviourists viewed inappropriate sexual urges as "learned" through early sexual experiences that created associations with the deviant stimuli and were then maintained through masturbation and fantasy. Early articles on behavioural treatments focussed on case reports, with the majority utilizing some form of aversion therapy (Marshall, Anderson, & Fernandez, 1999). Socially condoned negative views of sexual offenders likely contributed to the early general acceptance of aversive techniques for the treatment of sexual deviance (Marshall et al., 1999).

Current approaches to sexual offender treatment are considerably more comprehensive, incorporating cognitive-behavioural and social learning approaches in addition to behavioural strategies. In fact, the Safer Society Survey (2000) of sexual offender treatment programmes reported that the most commonly reported treatment approach for sexual offenders is cognitive-behavioural and delivered in a group format.

Issues targeted in modern sexual offender treatment programs have become quite standardized making it relatively easy to design or adapt existing sexual offender treatment programs for implementation. Current thinking has identified four domains of psychological risk factors for sexual offenders (Craissati & Beech, 2003; Hanson, 2000; Thornton, 2002) including: sexual arousal factors; attitudes tolerant of sexual assault; interpersonal deficits; and self-regulation deficits.

Hanson (2000) also included a fifth domain concerned with negative social environment, although this appears to be a more situational factor that could be addressed under self-regulation (Mann & Fernandez, 2005).

In terms of sexual arousal factors suitable targets for treatment include the reduction of deviant sexual arousal and fantasy, increasing arousal to consenting sex with other adults, and reduction of the level of importance placed on frequent sexual activity.

Within the domain of attitudes tolerant of sexual assault, assessment and treatment should address the way in which offenders view women and children and the way they interpret women's and children's behaviour, their beliefs about the lack of harm caused by sexual offending, and the way in which they see their rights towards these women and children in terms of sexual activity.

When targeting "Interpersonal Deficits" treatment programs should address poor adult relationship skills, intimacy and attachment problems, over-sexualisation of relationships, failure to relate to others in emotionally supportive and intimate ways, difficulties with self-disclosure, and conflict resolution. Finally, "Self-regulation" problems can be divided into three areas (Thornton, 2002): lifestyle impulsiveness, poor problem-solving, and lack of emotional regulation. Treatment programs should reduce impulsivity, teach the problem solving skills, and teach strategies for regulating emotions such as anger (Mann & Fernandez, 2005).

Of course not all sexual offenders will display all of these deficits. Treatment planning should include a comprehensive assessment and any program should be flexible enough to accommodate offenders with different risk factors working within the same programme. Further it is important that throughout the assessment process cultural issues are thoroughly considered (Cortoni 2000).

Duration of the treatment depends on the need for each offender. Thus it may range from relatively brief interventions of three months to a full year with a number of weekly sessions. Successful programs must deal with culture and beliefs and employ staff that is accepting, non-judgmental and able to build a good therapeutic rapport with clients.

Maintenance or follow-up programs should be available to reinforce treatment gains and aid offenders in enacting their self-management plans once they are released to the community. Participants are encouraged to attend for lengthy periods and use the maintenance group for support.

Authors' Notes

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