Chapter 14
Sexual Dysfunctions, Gender Dysphoria, and Paraphilic Disorders

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This chapter will focus on three different categories of mental disorders related to sexuality and gender: sexual dysfunctions, gender dysphoria, and paraphilic disorders. In general, sexual dysfunctions are conditions that affect one's ability to function sexually or to experience sexual pleasure; gender dysphoria is a condition in which distress is experienced due to an incongruence between one's experienced gender (i.e., the internal, psychological experience of one's gender) and one's assigned gender (i.e., how one's gender is perceived by others based on outward appearance); and paraphilic disorders are characterized by atypical, intense, and persistent sexual interests that cause distress or harm (or risk of harm). Typically, clinicians working in the area of sex therapy or sexual medicine will see clients with sexual dysfunctions and/or gender dysphoria, whereas clinicians who specialize in forensic psychology will see clients with paraphilic disorders, given that these disorders often entail legal consequences.

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D. L. Segal (ed.), *Diagnostic Interviewing*,
https://doi.org/10.1007/978-1-4939-9127-3_14

Description of the Disorders

Sexual Dysfunctions

According to the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013), sexual dysfunctions are characterized by disturbances in a person's ability to respond sexually or to experience sexual pleasure. Sexual dysfunctions consist of clinically significant issues with desire, interest, and arousal (e.g., erection), orgasm (including ejaculation), and genitopelvic pain and penetration, and they may be diagnosed as being due to the use of medications and/or substances. When more than one sexual dysfunction is present, all should be recorded (APA, 2013). If the presence of sexual dysfunctions can be explained by comorbid nonsexual mental disorders, such as anxiety or mood disorders, only the nonsexual disorder diagnosis (e.g., generalized anxiety) should be made (APA, 2013). In addition, the diagnosis of a sexual dysfunction requires that issues that are better explained by the effects of a medical condition or by severe relationship distress, partner violence, or other stressors are ruled out (APA, 2013).

There are seven sexual dysfunctions (Table 14.1; see the DSM-5 for three other designations [substance/medication-induced, other specified, and unspecified sexual dysfunctions]) that are diagnosable when the problem is associated with significant distress and has been present for a minimum of 6 months (APA, 2013). Subtypes are used to designate the *onset*, *context*, and *distress severity*. In terms of *onset*, "lifelong" refers to a sexual dysfunction that appears to have always been present, and "acquired" indicates that the sexual dysfunction developed after a period of non-problematic experiences. With respect to *context*, sexual dysfunctions may be restricted to certain types of stimulation, situations, or partners ("situational"), whereas "generalized" dysfunctions occur in all of these areas. *Distress severity* (i.e., mild, moderate, severe) should be documented for all sexual dysfunctions except for premature (early) ejaculation, in which the severity subtype corresponds to the client's estimate of ejaculatory latency during penetrative sexual activity (i.e., mild, 30–60 seconds; moderate, 15–30 seconds; severe, prior to or at the start of sexual activity, or within 15 seconds) (APA, 2013).

Table 14.1 DSM-5 sexual dysfunctions according to biological sex

Sexual response cycle phase affected	Males	Females
Desire/interest	Hypoactive sexual desire disorder	Sexual interest/arousal disorder
Excitement/arousal	Erectile disorder	
Orgasm	Delayed ejaculation Premature (early) orgasm	Orgasmic disorder
		Genitopelvic pain/penetration disorder

Although not explicitly stated in the DSM-5 (but stated in previous versions), the sexual dysfunctions are based on the first three stages of the four-phase sexual response cycle (Masters & Johnson, 1966): (1) desire/interest, which consists of fantasies about and the wish to engage in sexual activity; (2) excitement/arousal, which manifests as subjective sexual pleasure and associated physiological changes (e.g., genital lubrication and engorgement); and (3) orgasm, which consists of the release of sexual tension and the rhythmic contractions of genitopelvic muscles and organs. A problem at any one stage of the sexual response cycle is likely to lead to difficulties with other stages; indeed, clinically, a high comorbidity among the sexual dysfunctions is observed. For example, a client presenting with orgasm difficulties may also experience problems with desire/interest. In addition, genitopelvic pain can potentially interfere with any or all aspects of sexual response. Although sound empirical data on comorbidities are lacking, a recent consensus statement concluded that comorbidity among the sexual dysfunctions was more common among women than in men (McCabe et al., 2016).

Sexual desire and arousal disorders include hypoactive sexual desire disorder (HSDD) and erectile disorder (ED) for males and sexual interest/arousal disorder (SIAD) for females. The diagnosis of male HSDD is made when a client describes persistent or recurrent deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity (APA, 2013). Although the DSM-5 considers desire dysfunctions as distinct from arousal dysfunctions for males (i.e., there are separate diagnoses for HSDD and ED; see Table 14.1), this distinction is not made for females. Based on research indicating that women recognize a high degree of overlap in perceptions of sexual desire and arousal (Graham, Sanders, Milhausen, & McBride, 2004; note that emerging evidence also suggests the same for men), the DSM-5 includes the diagnosis of SIAD, which replaced the former diagnoses of female HSDD and female sexual arousal disorder (FSAD). SIAD is characterized by at least three of the following: absent/reduced (1) interest in sexual activity; (2) sexual/erotic thoughts or fantasies; (3) sexual excitement/pleasure during sexual activity in almost all or all (75–100%) sexual encounters; (4) sexual interest/arousal in response to any internal or external sexual/erotic cues; and (5) genital/non-genital sensations during sexual activity (75–100% of encounters); and no/reduced initiation of sexual activity and typically unreceptive to a partner's attempts to initiate (APA, 2013). The prevalence of desire disorders in women is estimated to be between 15 and 55%—with rates of 40–50% in those aged 65 years and above—and between 15 and 25% in men (McCabe et al., 2016). A diagnosis of ED is made when at least one of the following three symptoms are experienced on all or almost all (75–100%) sexual encounters: marked difficulty in *obtaining* or *maintaining* an erection or a marked *decrease in erectile rigidity* (APA, 2013). A wide range of prevalence rates is reported for ED (i.e., 15–76%) as rates vary with age; overall, the prevalence rate of ED in the USA is 22% (McCabe et al., 2016).

Orgasmic disorders consist of female orgasmic disorder (FOD) and, in males, delayed ejaculation (DE) and premature (early) ejaculation (PE). FOD is characterized by the presence of at least one of the following symptoms (experienced in 75–100% of sexual encounters): marked delay in, marked infrequency of, or absence

of orgasm and markedly reduced intensity of orgasmic sensations (APA, 2013). FOD is estimated to affect between 16 and 25% of women (McCabe et al., 2016). The diagnostic criteria for DE consist of at least one of the following symptoms (experienced in 75–100% of sexual encounters), without desiring the delay: marked delay in ejaculation and marked infrequency or absence of ejaculation (APA, 2013). The prevalence of DE is 1–10% (McCabe et al., 2016). PE, which affects approximately 8–30% of men of all ages (McCabe et al., 2016), is diagnosed when a patient describes a persistent or recurrent pattern of ejaculation experienced in 75–100% of partnered sexual encounters within approximately 1 min following vaginal penetration and before the individual wishes it. Note that these criteria can also be applied to nonvaginal penetration activities; however, specific duration criteria have not yet been established for these activities (APA, 2013).

Genitopelvic pain/penetration disorder (GPPPD) is a sexual dysfunction that is currently restricted to females; it affects between 14% and 27% of women (McCabe et al., 2016). The diagnosis of GPPPD involves persistent or recurrent difficulties with at least one of the following: (1) vaginal penetration during intercourse; (2) marked vulvovaginal/pelvic pain during vaginal intercourse or penetration attempts; (3) marked fear/anxiety about vulvovaginal/pelvic pain in anticipation of, during, or as a result of vaginal penetration; and (4) marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration (APA, 2013). The DSM-5 states that new research examining urologic pain in males suggests that a similar dysfunction may be diagnosable in the future (p. 439); its estimated prevalence is 16.8% (McCabe et al., 2016).

Gender Dysphoria

Gender dysphoria (GD) is characterized by an individual's affective/cognitive discontent (i.e., distress, dysphoria) that results from an incongruence between their experienced gender (i.e., the internal, psychological experience of their gender) and their assigned gender (i.e., how their gender is perceived by others based on their outward appearance) (APA, 2013). The diagnosis is made when the dysphoria is experienced for a minimum of 6 months and is associated with clinically significant distress or functional impairment. A diagnosis of GD is not solely based on gender role nonconformity (e.g., "tomboys"), and the following disorders need to be ruled out: transvestic disorder (i.e., the distressing or impairing behavior of cross-dressing for the purpose of sexual excitement), body dysmorphic disorder, schizophrenia or other psychotic disorders, or other clinical presentations (e.g., the desire to rid oneself of one's penis for aesthetic reasons, which is rare) (APA, 2013). In addition, clinical guidelines have been developed in response to the high co-occurrence between GD and autism spectrum disorder in adolescents (Strang et al., 2018).

As the expression of GD varies with age, the DSM-5 includes separate diagnostic criteria for children and adolescents/adults (see adapted criteria in Table 14.2). In children, the typical onset of cross-gender behaviors is between the ages of 2 and

Table 14.2 Diagnostic features for gender dysphoria in children and adolescents/adults

Gender dysphoria in children	Gender dysphoria in adolescents and adults
At least six of the following (including the first one, which is *required* for diagnosis): 1. A strong desire to be of the other gender or an insistence that one belongs to the other gender (or a different gender from one's assigned gender) 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female apparel; or in girls (assigned gender), a strong preference for wearing only typical masculine attire and a strong resistance to the wearing of typical feminine clothing 3. A strong preference for cross-gender roles in make-believe/fantasy play 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender 5. A strong preference for playmates of the other gender 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities 7. A strong dislike of one's sexual anatomy 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender	At least two of the following: 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics) 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics) 3. A strong desire for the primary and/or secondary sex characteristics of the other gender 4. A strong desire to be of the other gender (or a different gender from one's assigned gender) 5. A strong desire to be treated as the other gender (or a different gender from one's assigned gender) 6. A strong conviction that one has the typical feelings and reactions of the other gender (or a different gender from one's assigned gender)

Note: Adapted from the *DSM-5*

4 years, with more frequent expressions of anatomic dysphoria as one approaches puberty (APA, 2013). Based on recent studies, the overall prevalence of GD is estimated to be about 1% (Byne et al., 2018).

Paraphilic Disorders

The DSM-5 (APA, 2013) defines a paraphilia as an "intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (APA, 2013, p. 685). It distinguishes between a *paraphilia* (generally defined as an atypical, intense, and persistent sexual interest) and a *paraphilic disorder* (a paraphilia that causes distress or harm/risk of harm to others). There are eight specified paraphilic disorders (Table 14.3) and in each one, the specific focus of erotic interest

Table 14.3 The DSM-5 paraphilic disorders

Paraphilic disorders	Criterion A (and other relevant information), as manifested by fantasies, urges, or behaviors. Recurrent and intense sexual arousal from…	Criterion B
Voyeuristic disorder	…observing an unsuspecting person (who is at least 18 years of age) who is naked, in the process of undressing, or engaging in sexual activity	The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
Exhibitionistic disorder	…the exposure of one's genitals to an unsuspecting person	
Frotteuristic disorder	…touching or rubbing against a non-consenting person	
Sexual sadism disorder	…the physical or psychological suffering of another person	
Sexual masochism disorder	…the act of being humiliated, beaten, bound, or otherwise made to suffer	The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
Fetishistic disorder	…either the use of nonliving objects or a highly specific focus on non-genital body part(s)	
Transvestic disorder	…cross-dressing	
Pedophilic disorder	Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger)[a]	The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty

[a]The individual must be at least 16 years old and at least 5 years older than the child/children; must not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-olds

(minimum duration of 6 months) is characterized in Criterion A, and any distress, impairment, or harm that this interest causes is captured in Criterion B. Should an individual meet solely the requirements for Criterion A, then a paraphilia is identified. However, if the elements of Criterion B are also met, then a paraphilic disorder is diagnosed. This distinction reflects a line of thought in which an individual might harbor, for example, a sexual interest in children, in which case the presence of a paraphilia may be identified. However, it is only a paraphilic disorder if these feelings significantly impair the person's ability to function or if these feelings are acted upon, causing harm (or the risk of harm). Note that it is possible for individuals to have multiple paraphilias/paraphilic disorders. In addition to specified paraphilias, the DSM-5 acknowledges a broad range of other paraphilias (e.g., necrophilic disorder), which are recorded as "other specified" paraphilias/paraphilic disorders

when the nature of the non-normative interest is clear and as "unspecified" paraphilias/paraphilic disorders when it is not.

In terms of the course specifiers, both the terms "in full remission" and "in a controlled environment" can generally be applied to the paraphilic disorders. An exception is that pedophilic disorders cannot be declared to be in remission, which has fostered some debate (e.g., Briken, Fedoroff, & Bradford, 2014). These specifiers were incorporated to reflect the potential for a person to greatly reduce the likelihood of acting on paraphilic interests, thereby countervailing distress, impairment, and the potential for harm. Under such conditions, the paraphilia remains, but the paraphilic disorder is deemed to be in remission. The specifier regarding the presence of a controlled environment was included because many individuals who have acted on paraphilic interests have restrictions on their liberty, thereby rendering it difficult to assess their ongoing tendencies.

With regard to the prevalence of paraphilic disorders, the DSM-5 cautions that there is considerable uncertainty. It is estimated that the percentage of males who have acted on such paraphilic impulses is (at most) 12% for voyeuristic disorder, 2–4% for exhibitionistic disorder, 10–14% for frotteuristic disorder, and around 3–5% for pedophilic disorder (APA, 2013). All rates are higher for males than females and sometimes substantially so. The reasons for this disparity are unclear, although sexual drive has been proposed as a mediator (Dawson, Bannerman, & Lalumière, 2016), and there is some suggestion that rates are somewhat higher for women than previously reported (Joyal & Carpentier, 2017).

Procedures for Gathering Information

Sexual Dysfunctions

The clinical interview is the main technique with which to assess and diagnose sexual dysfunctions. There is no widely used, validated, standardized interview as is the case for most other DSM-5 disorders. However, several authors have proposed clinical interview guidelines and recommendations about coverage of topics and process (e.g., Maurice, 1999 [available for free download at https://kinseyinstitute.org/collections/archival/sexual-medicine-in-primary-care.php]; Meana, Binik, & Thaler, 2008; Wincze & Carey, 2015).

The clinical interview typically starts with the individual describing the nature of the problem and the reason for seeking treatment. Following an open-ended description of the problem, the clinician may ask more specific questions about when the problem started (onset), the conditions under which it occurs (context), and the extent of the problem and amount of distress experienced because of the issue (severity). Questions can then be asked about the various biological, psychological, and social problems that might be implicated (Meana et al., 2008). In terms of general biological factors, the clinician should assess and take into account age,

general health status (e.g., body mass index), lifestyle factors (e.g., diet, cigarette smoking), hormone levels, chronic pain syndromes (e.g., chronic prostatitis syndrome, vulvodynia), and medical illnesses that affect vascular, sensory, and central nervous system functions. In addition, questions regarding past surgeries and injuries, especially those in the genital or pelvic region, and past and current medications should be posed (Meana et al., 2008). It is commonly understood that many medications, such as antidepressants, antipsychotics, and antihypertensives, can detrimentally affect sexual functioning.

With respect to individual psychological factors, depression and anxiety are often comorbid with sexual dysfunction. If present and treatment does not target the associated mood disorders, treatment will likely not be successful. Substance abuse disorders may also have a major impact on sexual functioning. Certain maladaptive cognitive sets, unrealistic expectations, misinformation or lack of information, and negative emotional reactions can also impinge upon sexual function. Past sexual trauma and other negative experiences may set the foundation for sexual problems as well (Meana et al., 2008). Socially, family-of-origin attitudes regarding sexuality may be instilled early on and predispose the development of a sexual dysfunction. Assessing the quality of the individual's current relationship is of utmost importance, as problems between the members of the couple may be a cause and/or a consequence of sexual problems. If so, these issues need to be appropriately addressed. Areas of inquiry related to the couple should include anger, distrust, discrepancies in sexual drive and preferences, communication, and physical attraction (Meana et al., 2008). The comorbidity of partner sexual dysfunction is common and should be assessed and addressed if the partner is willing to be present in the sessions. In addition, ethnocultural and religious attitudes and beliefs are important as they can be implicated in the development and maintenance of sexual dysfunctions (Meana et al., 2008; Hall & Graham, 2012).

Questionnaires can be used to formally assess the presence and/or comorbidity of sexual dysfunctions. In addition, information from the client's treating physician with respect to results from laboratory tests (e.g., for hormone function, vascular integrity, nerve function) and physical examinations (e.g., gynecological) will provide useful information for diagnosis and treatment.

Gender Dysphoria

The most recent guideline for the standards of care for gender-diverse individuals—published by the World Professional Association for Transgender Health (WPATH) in 2011 and freely available at www.wpath.org/—outlines the process of assessment of individuals with GD. The role of mental health care providers on this team generally consists of a comprehensive psychosocial assessment of GD for the purpose of diagnosis. At a minimum, the following should be evaluated: gender identity and dysphoria, history and development of feelings of gender dysphoria, the impact of stigma related to any expression of gender nonconformity on mental health, and the

availability of social support (WPATH, 2011). If the individual meets the criteria for a diagnosis of GD, then information regarding options for gender identity and expression, as well as possible medical interventions (along with potential side effects and information about reversibility/permanence) and liaisons with relevant support groups, should be discussed and appropriate referrals made (WPATH, 2011). Given that individuals with GD may struggle with a range of mental health conditions (e.g., anxiety, self-harm, depression, personality disorders, autism spectrum disorder), mental health care providers should screen for these concerns and incorporate them into the overall treatment plan (e.g., providing or recommending therapy and/or psychotropic medications); addressing these issues can facilitate the process of transitioning (WPATH, 2011). Note that although a mental health assessment is needed for referral to hormonal/surgical treatments for GD, psychotherapy for the purpose of maximizing a person's overall psychological well-being, quality of life, and self-fulfillment is recommended, but not required (WPATH, 2011).

Should hormone therapy and/or surgery be a goal of the client, then the mental health care provider can assess whether the client is eligible and aware of the process (e.g., medical assessment to ensure there are no contraindications) as well as the benefits and effects of this treatment avenue (e.g., reproductive options, realistic expectations) in order to ensure that they are psychologically and practically prepared (WPATH, 2011). The type of information that should be documented in a referral letter for hormone therapy/surgery is summarized in Table 14.4. Note that additional letters from other health care providers may be necessary for medical intervention, and the number and type of letters depends on location.

Paraphilic Disorders

This section will focus on assessment procedures of adult males with paraphilic disorders. Very few females are identified with paraphilias, especially in forensic populations (for a review, see Cortoni, 2018); in addition, paraphilic disorders are

Table 14.4 Recommended content of referral letters for hormone therapy/surgery

Recommended content
1. The client's general identifying characteristics
2. Results of the client's psychosocial assessment, including any diagnoses
3. The duration of the referring health care provider's relationship with the client, including the type of evaluation and therapy or counseling to date
4. An explanation that the criteria for hormone therapy/surgery have been met and a brief description of the clinical rationale for supporting the client's request for hormone therapy
5. A statement about the fact that informed consent has been obtained from the patient
6. A statement that the referring health care provider is available for coordination of care and welcomes a phone call to establish coordination

generally not diagnosed in adolescence given that this period of sexual development is believed to be exploratory and fluid (Seto, Kingston, & Bourget, 2014).

Certain paraphilias and their associated disorders are more likely to be encountered in a forensic setting (e.g., pedophilic disorder), and others are more common in traditional mental health settings (e.g., masochistic disorder). In either case, the approach to the assessment will be similar, although a forensic setting is likely to be more concerned with broader issues such as risk to the public. In addition, those undergoing court assessments may be less inclined to be forthright than those seeking an assessment of their own volition. Regardless, the assessment will be facilitated by a warm, respectful, empathic, genuine, and supportive demeanor on the part of the interviewer (Wilcox & Gray, 2017). The Association for the Treatment of Sexual Abusers (ATSA; http://www.atsa.com/) offers practice guidelines for psychosexual evaluations, and these guidelines stress the need to use multiple sources of information, especially when the assessment is involuntary. Interviews should promote engagement, incorporate the client's perspective, and consider responsivity factors. Assessors are encouraged to gather information that includes, but is not limited to, the following: psychosexual development; the nature and frequency of sexual practices; paraphilic interests that may not be sexually abusive; the use of sexually oriented services or outlets (including pornography); abusive or offense-related sexual arousal, interests, and preferences; the history of sexually abusive behaviors; information about current and/or previous victim(s); contextual elements of sexually abusive behaviors; and the individual's level of insight, self-disclosure, and denial (ATSA, 2014, pp. 18–21).

Recommendations for Formal Assessment

Sexual Dysfunctions

Measures exist for virtually every issue related to sexual function. Included in Table 14.5 are commonly used questionnaires for the assessment of sexual dysfunction; please refer to the *Handbook of Sexuality-Related Measures* (Milhausen, Sakaluk, Fisher, Davis, & Yarber, 2018, forthcoming) for additional measures.

Gender Dysphoria

Table 14.6 includes commonly used questionnaires for the assessment of gender identity/dysphoria.

Table 14.5 Questionnaires used for the assessment of sexual dysfunctions

Questionnaire	Description
[1]Female sexual functioning index (FSFI)	Measures global sexual functioning, includes domain scores for desire, arousal, lubrication, orgasm, satisfaction, and pain; a modified version[2] has been validated for women with same-sex partners
[3]Vulvar pain assessment questionnaire (VPAQ)	Assesses vulvar pain characteristics, effects of vulvar pain on various aspects of life, coping strategies used, and romantic partner factors
[4]Sexual interest and desire inventory for females (SIDI-F)	Quantifies the severity of symptoms in women with sexual desire disorders
[5]International index of sexual functioning (IIEF)	Measures global sexual functioning, includes domain scores for erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction; a modified version[2] has been validated for men with same-sex partners[6]
[7]Premature ejaculation diagnostic tool (PEDT)	Assesses ejaculatory control and frequency, amount of stimulation needed for ejaculation, distress, and interpersonal difficulty
[8]Sexual distress scale (SDS)	Quantifies sexually related distress; validated for women and men[9]
[10]Dyadic adjustment scale (DAS)	Assesses dyadic cohesion, satisfaction, consensus, and affectional expression
[11]Sexuality questionnaire	A measure of gender identity and affectional and sexual orientation

[1]Rosen et al. (2000), [2]Boehmer, Timm, Ozonoff, and Potter (2012), [3]Dargie, Holden, and Pukall (2016), [4]Sills et al. (2005), [5]Rosen et al. (1997), [6]Coyne et al. (2010), [7]Symonds et al. (2007), [8]Derogatis, Rosen, Leiblum, Burnett, and Heiman (2002), [9]Santos-Iglesias, Mohamed, Danko, and Walker (2018), [10]Spanier (1976), [11]Alderson (2012)

Table 14.6 Questionnaires used for the assessment of gender identity/dysphoria

Questionnaire	Age group	Description
[1]Gender identity questionnaire (GIQ)	Children	This parent-report questionnaire has been validated as a screening tool for children with potential problems in their gender identity development
[2]Gender identity/gender dysphoria questionnaire (GIGDQ)	Adolescents and adults	This self-report measure assesses an individual's gender identity and gender dysphoria
[3]Sexuality questionnaire	Adolescents and adults	This self-report measure captures an individual's gender identity and affectional and sexual orientation

[1]Johnson et al. (2004), [2]Deogracias et al. (2007), [3]Alderson (2012)

Paraphilic Disorders

In addition to the clinical interview for paraphilias/paraphilic disorders, questionnaires (see Table 14.7 for an overview), viewing time, and phallometry may be used. These measures can provide important information given that some clients may be reluctant to divulge information regarding their paraphilic propensities.

Table 14.7 An overview of commonly used questionnaires used in the assessment of paraphilic disorders

Questionnaire	Domain
Multiphasic sex inventory (MSI) and the multiphasic sex inventory-II (MSI-II)	Characteristics of conventional and paraphilic sexual behaviors
The multidimensional inventory of development, sex, and aggression (MIDSA)	Sexual attitudes, fantasies, and behaviors
The Clarke sexual history questionnaire-revised (SHQ-R)	Different aspects of conventional and paraphilic sexuality
Paulhus deception scale (PDS)	Impression management
Psychopathy checklist-revised (PCL-R) for forensic assessments	Antisocial tendencies
The criminal sentiments scale (CSC)	Attitudes toward the justice system and the degree to which an individual is tolerant of law violations and identifies with other criminals
Abel and Becker cognitions scale (ABCS) and the Bumby RAPE and MOLEST scales	The dysfunctional thinking styles believed to facilitate sexual offenses
Stable-2007	Sexual and general self-regulation deficits
The Static-99 and the sex offender risk appraisal guide (SORAG)	Actuarial scale used for assessing sexual risk potential
The violence risk appraisal guide (VRAG)	Actuarial scale used for assessing risk of general violence in either sexual or nonsexual offenders
The Minnesota sex offender screening tool (MnSOST)	Screening tool to prioritize sex offenders for programs and level of community supervision

Questionnaires

The first and second editions of the Multiphasic Sex Inventory (MSI; Nichols & Molinder, 1984; MSI-II; Nichols & Molinder, 2000) measure a number of characteristics of conventional and paraphilic sexual behaviors. Moreover, both versions contain a treatment readiness scale that provides an index of an individual's receptivity to treatment. While the MSI has good psychometric properties (Seto et al., 2014), there are fewer studies regarding the MSI-II and its psychometric properties are less clear (Akerman & Beech, 2012).

The Multidimensional Inventory of Development, Sex, and Aggression (MIDSA, 2011) was developed to assess a range of sexual attitudes, fantasies, and behaviors. The developers have made available extensive development data (Akerman & Beech, 2012), and the scale has demonstrated acceptable psychometric properties (Seto et al., 2014).

The Clarke Sexual History Questionnaire-Revised (SHQ-R; Langevin & Paitich, 2002) covers different aspects of conventional and paraphilic sexuality. While it is vulnerable to response bias, Laws, Hanson, Osborn, and Greenbaum (2000) note that such measures can assist a broader evaluation of sexual proclivities. Moreover,

employing a test of impression management such as the Paulhus Deception Scales (PDS; Paulhus, 1999) can be a useful adjunct in assessing impression management response bias and, in the case of the PDS, an individual's level of personal insight.

Viewing Time and Choice Reaction Time

Viewing time (VT) and choice reaction time (CRT) measures (e.g., Abel Assessment of Sexual Interest; Abel, Huffman, Warberg, & Holland, 1998; PrefAssess; Gress, Brown, & Buttle, 2003) were developed to provide an objective but less intrusive assessment of sexual interests than phallometry (see below). These approaches employ measures of response delays induced by the preferred sexual content in stimuli to which the individuals are exposed. Typically, these response biases are quantified through differentials in VT or CRT. In reviewing two measures employing these indices, Gress, Anderson, and Laws (2013) found that adult sexual offenders had significantly longer average VT latencies than nonsexual offenders, but there was no effect for CRT. However, the VT measure in this study did not meet sensitivity or specificity criteria required to screen for the presence or absence of paraphilic propensities. Some believe the weak psychometric properties of these procedures render them better used as a clinical tool than a risk assessment measure (e.g., Akerman & Beech, 2012).

Phallometry

Phallometry involves the direct measurement of penile responses when individuals are exposed to auditory or visual sexual stimuli. These can vary on specific dimensions of interest (e.g., age, gender, and level of coercion). Phallometric responses are recorded as increases in either penile circumference or volume with indices reflecting differential responses to sex-typical and paraphilic themes. Phallometric measures have been well validated, although problems remain with a lack of standardization in terms of procedures and stimuli across evaluation centers. A recent meta-analysis (McPhail et al., 2017) supports the validity of phallometric testing for pedo-hebephilic propensities (i.e., sexual interests in prepubescent and pubescent children) especially if audio and slides are used; the use of video stimuli was not supported. While concerns about the faking of test responses are well grounded and counter measures are limited (Wilson & Miner, 2016), McPhail and colleagues stress that the validity of test results can be enhanced through the use of evidence-based practices and standardized procedures.

It is recommended that users be trained in phallometry and familiar with its strengths and limitations, because the results often carry a lot of weight (e.g., regarding access to biological children) (ATSA, 2014). Furthermore, the results of such testing should never be used in isolation but rather be incorporated as part of a broader consideration of assessment information.

Assessing Antisocial Tendencies

Adherence to antisocial values is associated with increased rates of nonsexual recidivism for both sexual and nonsexual offenders (Witte, Di Placido, Gu, & Wong, 2006), and the assessment of such sentiments is generally included as part of a comprehensive evaluation of sexual abusers. In their most extreme form, antisocial tendencies are highly associated with criminal behavior and, in their extreme, they present as psychopathy, which led Hare (2003) to develop the Psychopathy Checklist-Revised (PCL-R) for forensic assessments. Psychopathy is characterized by a lack of empathy or conscience, manipulative behaviors, deceitfulness, along with impulsive and irresponsible behavior. The PCL-R has become widely used and accepted by forensic psychologists and the courts (Murrie, Boccaccini, Caperton, & Rufino, 2012). However, these authors demonstrated that the validity of PCL-R is eroded when users are not rigorously trained. Moreover, a subset of items measuring persistent and versatile criminality and aggression (Facet 4) fared better than all other PCL-R elements.

Criminogenic values have also been linked to an increased risk to engage in antisocial behavior. The Criminal Sentiments Scale (CSC; Andrews & Wormith, 1984) measures attitudes toward the justice system and the degree to which an individual is tolerant of law violations and identifies with other criminals. A modified version (Simourd, 1997) has been shown to be a good predictor of future involvement in nonsexual criminal activity among sexual offenders (Witte et al., 2006).

Measuring Cognitions Related to Sexual Offending

Several scales have been developed to measure the dysfunctional thinking believed to facilitate sexual offenses. Examples include the Abel and Becker Cognitions Scale (ABCS; Abel, Becker, & Cunningham-Rathner, 1984) and the Bumby RAPE and MOLEST scales (Bumby, 1996). However, while these scales may have value in reflecting changes made in treatment, such changes may be unrelated to future sexual recidivism (Nunes, Pettersen, Hermann, Looman, & Spape, 2016). As such, they should probably not be regarded as reflecting differences associated with changes in sexual risk potential.

Examining Self-Regulation

Given that self-regulation deficits have been associated with sexual recidivism, the Stable-2007 (Hanson, Harris, Scott, & Helmus, 2007) incorporates six items pertaining to sexual and general self-regulation deficits. Hanson et al. note that higher scores on these items predicted risk for both sexual and nonsexual violence.

Risk Assessment

In employing risk scales, assessors must necessarily be mindful of the potential for the individuals being assessed to be deceitful in their efforts to obtain an evaluation that is favorable to them. As noted earlier, ATSA (2014) practice guidelines stress the need to include diverse and independent sources of information; doing so will greatly increase the validity of the scores obtained on risk assessment scales. If such information is lacking, a note to this effect should be made as a limitation of the assessment.

The period since the mid-1990s has seen tremendous strides in the development of risk assessment scales for sexual offenders (Harris & Hanson, 2010). The Static-99 (Hanson & Thornton, 2000) is an actuarial scale that is in use globally for assessing sexual risk potential. It has been validated with many cultural groups and across several countries, but some caution needs to be exercised when using it (Phenix et al., 2016); Haag, Boyes, Cheng, MacNeil, and Wirove (2016) note that risk assessment tools can perform less well with certain cultural groups (e.g., indigenous offenders in Canada), so keeping their limitations in mind is recommended (Gutierrez, Helmus, & Hanson, 2016).

The original Static-99 has undergone revisions in terms of structure and norms and is currently referred to as the Static-99R (Hanson, Thornton, Helmus, & Babchishin, 2016; Phenix et al., 2016). The obtained score on this actuarial scale is compared with a large database of offenders from several countries, and the sexual recidivism rates for those with a similar score over 5 years can be accessed.

The Sex Offender Risk Appraisal Guide (SORAG; Quinsey, Harris, Rice, & Cormier, 2006) is also a widely used actuarial scale. The SORAG items include considerations of an individual's offense history, school adjustment, alcohol use, and the presence of personality disorders and incorporate the PCL-R score among other factors. The obtained score is compared to actuarially derived recidivism rates for offenders with similar scores over 7 and 10 years. A related scale, the Violence Risk Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993), may be employed to assess the risk of general violence in either sexual or nonsexual offenders. A revised version, the VRAG-R, may be used in place of both the VRAG and SORAG (Rice, Harris, & Lang, 2013). It is more efficient, incorporating just the Facet 4 items from the PCL-R.

Since its introduction in the mid-1990s, the Minnesota Sex Offender Screening Tool (MnSOST; Epperson, Kaul, & Huot, 1995) and its most recent derivative (the MnSOST-3; Duwe & Freske, 2012) have been widely used in screening sex offenders to prioritize them for sex offender programs and the level of community supervision required (Duwe, 2017).

While actuarial scales include the most robust risk predictors, these scales tend to be static and preclude the measurement of dynamic factors (e.g., the establishment of prosocial sources of support). To address this limitation, Hanson et al. (2007) developed the Stable-2007 that includes 13 dynamic risk factors associated with sexual recidivism (e.g., significant social influences, capacity for relationship

stability, emotional identification with children). The tool can be used in conjunction with the Static-99R to determine risk, program priority, and treatment goals.

The Violence Risk Scale: Sex Offender Version (VRS:SO; Olver, Wong, Nicholaichuk, & Gordon, 2007; Olver et al., 2018) contains 7 static and 17 dynamic risk factors designed to assess sexual risk, assist in treatment planning, and identify changes in risk as a result of treatment or other reasons.

A recent trend is a growing emphasis on factors associated with a lowered probability of antisocial behavior rather than risk factors per se. For example, de Vries, de Vogel, Koster, and Bogaerts (2015) have developed the Structured Assessment of Protective Factors for violence risk (SAPROF), employing factors positively associated with desistance from sexual offending.

Case Illustrations

Case 1

Kelly (early 20s) was referred to sex therapy by her general practitioner for "painful sex." Her spouse of 3 years (David, also in his 20s) attended the sex therapy sessions. Kelly and David had abstained from sexual intercourse until their wedding night in keeping with their religious beliefs. In David's words, "the wedding night was a disaster." Kelly appeared very nervous and when they tried to have intercourse; she winced and complained of pain when he attempted vaginal penetration. The couple continued their attempts over the next few months and, although penetration eventually became possible, it remained intensely painful for Kelly. She also reported discomfort with tampon insertion and internal pelvic examinations, although of lower intensity. They had settled into a pattern of sexual interactions characterized by David's entreaties to have sex, Kelly's increasingly anxious attempts to avoid it, and the occasional sexual interaction (about once per month) that was painful for Kelly and unsatisfying for both. They rarely discussed the problem. Kelly reported experiencing sexual desire and arousal during nonpainful sexual activities, but her desire/arousal plummeted when she anticipated or experienced the pain. In terms of their past, both reported supportive families and a generally happy childhood, with no history of physical or sexual abuse. They had no mental health concerns. David reported no sexual concerns, and they both reported a strong and satisfying nonsexual relationship.

Areas targeted with psychometric measures were sexual dysfunction, pain-related experiences, and relationship adjustment. Consistent with the information obtained during the clinical interview, FSFI scores supported the diagnosis of GPPPD for Kelly, and the IIEF did not reveal evidence of sexual dysfunction in David. A pain scale revealed high pain intensity scores, and Kelly's scores on measures of pain catastrophizing and anxiety were very high. The DAS confirmed their report of having a satisfying relationship outside of sexual activity. A referral was made to a gynecologist and a pelvic floor physical therapist with expertise in

genitopelvic pain; results were consistent with a diagnosis of provoked vestibulodynia (PVD), a common cause of genitopelvic pain, with considerable hypertonicity (tightness) of the pelvic floor musculature. The findings from this assessment were used to design a multidisciplinary treatment plan that simultaneously targeted all problem areas: genitopelvic pain; feelings of guilt related to, and communication about, sex; hypertonicity; and pain catastrophizing and anxiety.

Case 2

Sarah, a 28-year-old transwoman, was referred to sex therapy by her family doctor in order to obtain a letter for hormone therapy as this step was the next one in her physical transition to a feminine body. Sarah was designated male at birth, but since early childhood (3–4 years of age) recalled feeling distressed about "being a boy," the stereotypical male toys that she was expected to play with, and the male clothing she was expected to wear. She identified as a girl since the age of 5. In her early school years, she avoided sports and all forms of rough-and-tumble play, played only with girls (and typically feminine toys), preferred to wear her hair long, and wore feminine clothing. When asked what she wanted to be "when she grew up," Sarah would often respond, "a woman." Although she was often bullied by other children (typically males), her parents, most other family members, and friends (girls) never questioned her choices. As Sarah approached puberty, she noted a sharp increase of distress (severe level) given the more obvious masculine changes that were occurring in her body, especially the growth of facial hair, the development of the typical male body contour, and the deepening of her voice. Sarah expressed sexual interest in females and dated several partners throughout high school and beyond, eventually marrying her current partner, Samantha, at the age of 25. Sarah was always open about her felt gender with her partners, and Samantha was described as supportive of any changes that Sarah opted for in terms of her journey as a woman. Sarah dressed femininely, wore make-up and nail polish, and was working with a voice coach in order to raise her pitch. She also wore a padded bra to feel and appear feminine. She was "out" in the trans community as well as with all close individuals in her social network, and she felt that she was ready to take the next step in terms of her physical transition (hormone therapy). Her distress level in terms of her physical body and being "misread" by others as male/man was moderate to high. She expressed realistic expectations in terms of the changes that hormone therapy entailed, she understood the risks and benefits of the treatment, and she recognized the reproductive implications of the treatment. She was not interested in surgery at this time.

Upon examining her responses to the GIGDQ, Sarah's gender identity was that of a woman, and her dysphoria was moderate to high. Her scores on anxiety and depression screening tools were in the moderate range. A letter detailing the diagnosis of GD and including the information required by WPATH (Table 14.4) was sent to a physician who was trained in hormone therapy for gender-diverse individuals

in order to support Sarah's request for hormone therapy. In addition, Sarah was given a referral to a trans-friendly mental health care provider to develop coping strategies for her depression and anxiety.

Case 3

John (age 56) was convicted of breaching a court order prohibiting contact with children. He babysat a six-year-old boy who disclosed he had been kissed on the mouth. John has ten prior sentencing dates over 30 years for a range of offenses; five of these were for sexual offenses. All involved boys aged 7–15. John was raised in an intact family by prosocial parents. However, he said his brother bullied him, which contributed to him acting out in school where his peers ostracized him. Behavioral problems emerged in elementary school, and many suspensions resulted. He was expelled in Grade 11, which ended his formal education. Throughout his adult years, John continued to struggle to make friends but enjoyed the support of his family. He spent most of his free time alone and at home, which he preferred. John reported having been sexually abused by an adult male neighbor when he was 7 years old. According to John, he did not see this experience as harmful. He had never been in a cohabiting relationship with an age-appropriate partner but expressed that he would like to be. He described being sexually attracted to adult males and acknowledged an interest in boys aged 14–16.

John participated in a treatment program in 2006. The treatment report noted that few gains were made. He was described as being unreceptive to feedback and steadfast in asserting his victims "accepted and enjoyed" the abuse. He repeated this belief in the current assessment and stressed that he never pressured them and referred at times to having had a "relationship" with them. In regard to his current breach, John described it as "no big deal." He denied kissing the boy and portrayed his contact with the youth as a benign attempt to help a neighbor who required childcare at short notice. He had no insight into his role in engineering these circumstances or others that gave him access to his victims, whom he portrayed as the initiators of the sexual activity.

On the PDS, John's scores revealed that his level of personal insight was poor. Scores on the MSI-II and Bumby MOLEST scales confirmed the presence of well-entrenched and enduring cognitive distortions; for example, he endorsed "strongly agree" in reference to the statements "Some sexual relations with children are a lot like adult sexual relationships" and "Society makes a much bigger deal out of sexual activity with children than it really is." John underwent a phallometric evaluation of sexual preferences, revealing equivalent responses to both pubescent and prepubescent boys, a secondary but significant response to consenting adult males, and a negligible response to females of any age. The results of the interview and testing were consistent with pedophilic disorder. His PCL-R score was below the criterion for designation as a psychopath. John's scores on the Static-99R and VRAG-R indicated a very strong risk of reoffending. On the Stable-2007, John's results revealed

a combination of positive and negative ratings, reflecting a high level of stable dynamic needs. In aggregating the scores on the Static-99R, VRAG-R, and Stable-2007, John was appraised as representing a very high risk to reoffend sexually. A high-intensity sex offender program was recommended. Treatment targets included addressing the lack of positive social influences in his life, facilitating efforts to establish an age-appropriate relationship, cognitive distortions related to his offenses, improving sensitivity to victim impact issues, improving problem-solving skills, and providing him with strategies for coping with his paraphilic proclivities.

Impact of Gender, Race, Culture, and Other Aspects of Diversity

An extensive discussion of the impact of race, culture, diversity, and age for sexual dysfunctions, gender dysphoria, and paraphilic disorders is beyond the scope of this chapter (see Hall & Graham, 2012 for a book on this topic). In all therapies, an interconnectedness perspective can hold much explanatory and clinical potential. Among other recommendations, Hardy and Laszloffy (2002) encourage therapists to view all therapy as cross-cultural and to engage in a constant process of self-exploration. More practically, it is essential for therapists to work respectfully within clients' religious and other beliefs and to recognize diversity in experiences, orientations, genders, and sociocultural circumstances.

Information Critical to Making a Diagnosis

Critical information needed for diagnosis includes the following:

1. A detailed description of the presenting issue.
2. Personal significance attached to the presenting issue.
3. Level of distress and areas of life affected.
4. Onset of the problem.
5. Frequency of the difficulty.
6. Patterns of the behavior.
7. What is the reason for seeking treatment at this time?
8. If partnered, how is the issue affecting the partner?
9. Information related to current/past partners/relationships and social support.
10. Sexual history, including information related to negative experiences (e.g., abuse).
11. Medical and psychiatric history, including past and present medications and surgeries.
12. Alcohol and drug use and abuse.

13. Sex/gender, gender identity, sexual orientation, and sexual identity.
14. Content and frequency of sexual fantasies.
15. Family of origin issues.
16. Client's causal attributions for their difficulty.
17. Comorbid conditions.
18. Past or current convictions of problematic sexual behaviors.
19. Cultural and religious schemas.

Dos and Don'ts

Dos

1. Ask about sexual problems in a direct manner no matter what the presenting complaint.
2. Be open and nonjudgmental.
3. Recognize diversity in all aspects of sexual and gender identity.
4. Understand and respect the clients' religious and cultural beliefs.
5. Provide normalizing statements and gently correct misinformation.
6. Ask about solitary sexual activities in addition to partnered activities.
7. Gaining information into fantasies may provide additional insight into the presenting complaints.
8. Ask questions about activities (e.g., anal sex) that are important for sexual health.
9. Ask about partner communication and the partner's responses to the presenting complaint.
10. If working with a sex offender, gain information from as many sources as possible in order to obtain as comprehensive a history as possible.
11. Refer to a medical doctor for physical tests, laboratory investigations, and treatment.
12. If the individual is partnered, encourage the participation of both partners in assessment and treatment.

Don'ts

1. Don't let lack of experience or discomfort with sexual issues prevent you from at least asking some screening questions about sexual dysfunctions; open the door for the client to discuss this topic and see if a referral may be needed if you do not feel competent. Most people will not spontaneously bring up a sexual problem. Direct questions must be asked.

2. Don't assume that you know everything about the client and his/her fantasies, sexual orientation, relationship status, sexual experiences, gender identity, etc.
3. Don't assume that sex and gender are binary concepts.
4. Don't assume that older people, single people, disabled persons, people with intellectual issues, etc., are not sexual or sexually active.
5. In the case of sex offenders or individuals convicted of sexual crimes, don't believe everything they tell you as they may want to mislead the clinician into thinking that they are functioning at higher or lower levels depending on the situation.

Summary

There are a number of disorders related to sexuality, gender, and paraphilias, and each must be carefully assessed and characterized. At a minimum, a single question about any sexual concern is necessary to potentially raise an issue that the patient may want to address but feels too embarrassed to spontaneously report.

References

Abel, G. G., Becker, J. V., & Cunningham-Rathner, J. (1984). Complications, consent, and cognitions in sex between children and adults. *International Journal of Law and Psychiatry, 7*, 89–103. https://doi.org/10.1016/0160-2527(84)2990008-6

Abel, G. G., Huffman, J., Warberg, B., & Holland, C. L. (1998). Visual reaction time and plethysmography as measures of sexual interest in child molesters. *Sexual Abuse: A Journal of Research and Treatment, 10*, 81–95. https://doi.org/10.1177/107906329801000202

Akerman, G., & Beech, A. R. (2012). A systematic review of measures of deviant sexual interest and arousal. *Psychiatry, Psychology and Law, 19*(1), 118–143. https://doi.org/10.1080/13218719.2010.547161

Alderson, K. G. (2012). *Counseling LGBTI clients*. Thousand Oaks, CA: Sage.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Andrews, D. A., & Wormith, J. S. (1984). *The criminal sentiments scale*. Ottawa, Canada: Ministry of Correctional Services of Canada.

Association for the Treatment of Sexual Abusers. (2014). *ATSA practice guidelines for assessment, treatment interventions, and management strategies for male adult sexual abusers*. Beaverton, OR: Professional Issues Committee, ATSA.

Boehmer, U., Timm, A., Ozonoff, A., & Potter, J. (2012). Applying the Female Sexual Functioning Index to sexual minority women. *Journal of Women's Health, 21*(4), 401–409.

Briken, P., Fedoroff, J. P., & Bradford, J. W. (2014). Why can't pedophilic disorder remit? *Archives of Sexual Behavior, 43*, 1237–1239. https://doi.org/10.1007/s10508-014-0323-1

Byne, W., Karasic, D. H., Coleman, E., Eyler, A. E., Kidd, J. D., Meyer-Bahlburg, H. F., … Pula, J. (2018). Gender dysphoria in adults: An overview and primer for psychiatrists. *Transgender Health, 3*(1), 57–73.

Bumby, K. M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. *Sexual Abuse: A Journal of Research and Treatment, 8*, 37–54.

Cortoni, F. (2018). *Women who sexually abuse: Assessment, treatment & management*. Brandon, VT: Safer Society Press.

Coyne, K., Mandalia, S., McCullough, S., Catalan, J., Noestlinger, C., Colebunders, R., & Asboe, D. (2010). The International Index of Erectile Function: Development of an adapted tool for use in HIV-positive men who have sex with men. *The Journal of Sexual Medicine, 7*(2.1), 769–774.

Dargie, E. E., Holden, R., & Pukall, C. F. (2016). The vulvar pain assessment questionnaire inventory. *Pain, 157*, 2672–2686.

Dawson, S. J., Bannerman, B. A., & Lalumière, M. L. (2016). Paraphilic interests: An examination of sex differences in a non-clinical sample. *Sexual Abuse: A Journal of Research and Treatment, 28*(1), 20–45.

Deogracias, J. J., Johnson, L. L., Meyer-Bahlburg, H. F., Kessler, S. J., Schober, J. M., & Zucker, K. J. (2007). The gender identity/gender dysphoria questionnaire for adolescents and adults. *Journal of Sex Research, 44*(4), 370–379.

de Vries, M., de Vogel, V., Koster, K., & Bogaerts, S. (2015). Assessing protective factors for sexually violent offending with the SAPROF. *Sexual Abuse: A Journal of Research and Treatment, 27*, 51–70. https://doi.org/10.1177/1079063214550168

Derogatis, L. R., Rosen, R., Leiblum, S., Burnett, A., & Heiman, J. (2002). The Female Sexual Distress Scale (FSDS): Initial validation of a standardized scale for assessment of sexually related personal distress in women. *Journal of Sex & Marital Therapy, 28*(4), 317–330.

Duwe, G. (2017). Better practices in the development and validation of recidivism risk assessments: The Minnesota Sex Offender Screening Tool-4 (MnSOST-4). *Criminal Justice Policy Review.* Advance online publication. https://doi.org/10.1177/0887403417718608

Duwe, G., & Freske, P. (2012). Using logistic regression modeling to predict sex offense recidivism: The Minnesota Sex Offender Screening Tool-3 (MnSOST-3). *Sexual Abuse: A Journal of Research and Treatment, 24*, 350–377. https://doi.org/10.1177/107906321142947

Epperson, D. L., Kaul, J. D., & Huot, S. J. (1995, October). *Predicting risk of recidivism for incarcerated sex offenders: Updated development on the Sex Offender Screening Tool (SOST)*. Paper presented at the 14th annual conference of the Association for the Treatment of Sexual Abusers, New Orleans, LA.

Graham, C. A., Sanders, S. A., Milhausen, R. R., & McBride, K. R. (2004). Turning on and turning off: A focus group study of the factors that affect women's sexual arousal. *Archives of Sexual Behavior, 33*(6), 527–538.

Gress, C. L. Z., Anderson, J. O., & Laws, D. R. (2013). Delays in attentional processing when viewing sexual imagery: The development and comparison of two measures. *Law and Criminological Psychology, 18*, 66–82. https://doi.org/10.1111/j.2044-8333.2011.02032.x

Gress, C. L. Z., Brown, J., & Buttle, T. (2003). PrefAssess: A viewing time measure of sexual interest (version 1.0) [Computer program]. Limestone Technologies, Kingston, Ontario, Canada.

Gutierrez, L., Helmus, L. M., & Hanson, R. K. (2016). What we know and don't know about risk assessment with offenders of indigenous heritage. *Journal of Threat Assessment and Management, 3*(2), 97–106. https://doi.org/10.1037/tam0000064

Haag, A. M., Boyes, A., Cheng, J., MacNeil, A., & Wirove, R. (2016). An introduction to the issues of cross-cultural assessment inspired by Ewert v. Canada. *Journal of Threat Assessment and Management, 3*(2), 65–75. https://doi.org/10.1037/tam0000067

Hall, K. S., & Graham, C. A. (Eds.). (2012). *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients*. New York, NY: Routledge.

Hanson, R. K., Harris, A. J. R., Scott, T.L., & Helmus, L. (2007). *Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project* (User report, Corrections research). Ottawa, Canada: Public Safety Canada. Retrieved from http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ssssng-rsk-sxl-ffndrs/index-eng.aspx

Hanson, R. K., Thornton, D., Helmus, L. M., & Babchishin, K. M. (2016). What sexual recidivism rates are associated with Static-99R and Static-2002R scores? *Sexual Abuse, 28*, 218–252. https://doi.org/10.1177/1079063215574710

Hanson, R. K., & Thornton, D. (2000). Improving risk assessment for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior, 24*, 119–136. https://doi.org/10.1023/A:1005482921333

Harris, A. J. R., & Hanson, R. K. (2010). Clinical, actuarial, and dynamic risk assessment of sexual offenders: Why do things keep changing? *Journal of Sexual Aggression, 16*, 296–310. https://doi.org/10.1080/13552600.2010.494772

Hardy, K. V., & Laszloffy, T. A. (2002). Couple therapy using a multicultural perspective. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 569–593). New York, NY: Guilford.

Hare, R. D. (2003). *Manual for the revised psychopathy checklist* (2nd ed.). Toronto, ON: Multi-Health Systems.

Harris, G. T., Rice, M. E., & Quinsey, V. L. (1993). Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior, 20*, 315–335. https://doi.org/10.1177/0093854893020004001

Johnson, L. L., Bradley, S. J., Birkenfeld-Adams, A. S., Kuksis, M. A. R., Maing, D. M., Mitchell, J. N., & Zucker, K. J. (2004). A parent-report gender identity questionnaire for children. *Archives of Sexual Behavior, 33*(2), 105–116.

Joyal, C. C., & Carpentier. (2017). The prevalence of paraphilic interests and behaviors in the general population: A provincial survey. *Journal of Sex Research, 54*(2), 161–171.

Langevin, R., & Paitich, D. (2002). *Clarke sexual history questionnaire for males-revised technical manual*. Toronto, Canada: Multi-Health Systems.

Laws, D. R., Hanson, R. K., Osborn, C. A., & Greenbaum, P. E. (2000). Classification of child molesters by plethysmographic assessment of sexual arousal and a self-report measure of sexual preference. *Journal of Interpersonal Violence, 15*, 1297–1312. https://doi.org/10.1177/088626000015012004

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. New York, NY: Bantam Books.

Maurice, W. L. (1999). *Sexual medicine in primary care*. St. Louis, MO: C. V. Mosby.

McCabe, M. P., Sharlip, I. D., Lewis, R., Atalla, E., Balon, R., Fisher, A. D., … Segraves, R. T. (2016). Incidence and prevalence of sexual dysfunction in women and men: A consensus statement from the Fourth International Consultation on Sexual Medicine 2015. *The Journal of Sexual Medicine, 13*(2), 144–152.

McPhail, I. V., Hermann, C. A., Fernane, S., Fernandez, Y. M., Nunes, K. L., & Cantor, J. M. (2017). Validity in phallometric testing for sexual interests in children: A meta-analytic review. *Assessment,* Advance online publication. https://doi.org/10.1177/1073191117706139

Meana, M., Binik, Y. M., & Thaler, L. (2008). Sexual dysfunction. In J. Hunsley & E. J. Mash (Eds.), *A guide to assessments that work* (pp. 464–487). New York, NY: Oxford University Press.

Milhausen, R. R., Sakaluk, J. K., Fisher, T. D., Davis, C. M. & Yarber, W. L. (Ed.). (2018, forthcoming). *The handbook of sexuality related measures* (4th ed.). New York, NY: Routledge.

Multidimensional Inventory of Development, Sex, and Aggression (MIDSA). (2011). *MIDSA clinical manual* (3rd ed.). Bend, OR: Augur Enterprises. Available at www.midsa.us

Murrie, D. C., Boccaccini, M. T., Caperton, J., & Rufino, K. (2012). Field validity of the Psychopathy Checklist–Revised in sex offender risk assessment. *Psychological Assessment, 24*(2), 524–529. https://doi.org/10.1037/a0026015

Nichols, H., & Molinder, I. (2000). *Multiphasic sex inventory II*. Fircrest, WA: Nichols & Molinder Assessments.

Nichols, H. R., & Molinder, I. (1984). *Multiphasic sex inventory manual*. Tacoma, WA: Nichols and Molinder Assessments.

Nunes, K. L., Pettersen, C., Hermann, C. A., Looman, J., & Spape, J. (2016). Does change on the RAPE and MOLEST scales predict sexual recidivism? *Sexual Abuse: A Journal of Research and Treatment, 28*(5), 427–447. https://doi.org/10.1177/1079063214540725

Olver, M. E., Mundt, J. C., Thornton, D., Beggs Christofferson, S. M., Kingston, D. A., Sowden, J. N., Nicholaichuk, T. P., Gordon, A., & Wong, S. C. P. (2018). Using the Violence Risk Scale-Sexual Offense Version in sexual violence risk assessments: Updated risk categories and recidivism estimates from a multisite sample of treated sexual offenders. Psychological Assessment. Advance online publication. https://doi.org/10.1037/pas0000538

Olver, M. E., Wong, S. C. P., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale-Sexual Offender version: Assessing sex offender risk and evaluating therapeutic change. *Psychological Assessment, 19*, 318–329. https://doi.org/10.1037/1040-3590.19.3.318

Paulhus, D. L. (1999). *Paulhus deception scales*. Toronto, Canada: Multi-Health Systems.

Phenix, A., Fernandez, Y., Harris, A. J. R., Helmus, M., Hanson, R. K., & Thornton, D. (2016). *Static-99R coding rules: Revised—2016*. Available from www.static99.org

Quinsey, V. L., Harris, G. T., Rice, M. E., & Cormier, C. A. (2006). *Violent offenders: Appraising and managing risk* (2nd ed.). Washington, DC: American Psychological Association.

Rice, M. E., Harris, G. T., & Lang, C. (2013). Validation of and revision to the VRAG and SORAG: The Violence Risk Appraisal Guide-Revised (VRAG-R). *Psychological Assessment, 25*, 951–965. https://doi.org/10.1037/a0032878

Rosen, C., Brown, J., Heiman, S., Leiblum, C., Meston, R., Shabsigh, D., … Agostino, R. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex & Marital Therapy, 26*(2), 191–208.

Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick, J., & Mishra, A. (1997). The international index of erectile function (IIEF): A multidimensional scale for assessment of erectile dysfunction. *Urology, 49*(6), 822–830.

Santos-Iglesias, P., Mohamed, B., Danko, A., & Walker, L. M. (2018). Psychometric validation of the Female Sexual Distress Scale in male samples. *Archives of Sexual Behavior, 47*(6):1733–1743. https://doi.org/10.1007/s10508-018-1146-2

Seto, M. C., Kingston, D. A., & Bourget, D. (2014). Assessment of the paraphilias. *The Psychiatric Clinics of North America, 37*(2), 149–161.

Sills, T., Wunderlich, G., Pyke, R., Segraves, R. T., Leiblum, S., Clayton, A., … Evans, K. (2005). The Sexual Interest and Desire Inventory-Female (SIDI-F): Item response analyses of data from women diagnosed with hypoactive sexual desire disorder. *The Journal of Sexual Medicine, 2*(6), 801–818.

Simourd, D. J. (1997). The Criminal Sentiments Scale-Modified and Pride in Delinquency Scale: Psychometric properties and construct validity of two measures of criminal attitudes. *Criminal Justice and Behavior, 24*(1), 52–70.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and Family, 38*, 15–28.

Strang, J. F., Meagher, H., Kenworthy, L., de Vries, A. L., Menvielle, E., Leibowitz, S., … Pleak, R. R. (2018). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child & Adolescent Psychology, 47*(1), 105–115.

Symonds, T., Perelman, M. A., Althof, S., Giuliano, F., Martin, M., May, K., … Morris, M. (2007). Development and validation of a premature ejaculation diagnostic tool. *European Urology, 52*(2), 565–573.

Wilcox, D. T., & Gray, R. (2017). Developing more effective interviewing skills with men who commit sexual offenses. In D. T. Wilcox, M. L. Donathy, R. Gray, & C. Baim (Eds.), *Working with sex offenders: A guide for practitioners*. Abingdon, UK: Routledge.

Wilson, R. J., & Miner, M. H. (2016). Measurement of male sexual arousal and interest using penile plethysmography and viewing time. In D. R. Laws & W. O'Donohue (Eds.), *Treatment of sex offenders* (pp. 107–131). Basel, Switzerland: Springer.

Wincze, J. P., & Carey, M. P. (2015). *Sexual dysfunction: A guide for assessment and treatment*. New York, NY: Guilford Publications.

Witte, T. D., Di Placido, C., Gu, D., & Wong, S. C. P. (2006). An investigation of the validity and reliability of the Criminal Sentiments Scale in a sample of treated sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 18*, 249–258.

World Professional Association for Transgender Health. (2011). Standards of care for the health of transsexual, transgender, and gender nonconforming people. World Professional Association for Transgender Health.