Chapter 3
Assessment and Basic Management Principles of Paraphilic Disorders

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Paraphilias vs. Paraphilic Disorders

The word paraphilia comes from the Greek word *para*, which means deviation, and *philia*, which means beyond usual love or attraction. The DSM-IV TR classifies paraphilias within the Sexual and Gender Identity disorders and defines them

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by recurrent intense, sexually arousing fantasies, sexual urges, or behaviors involving nonhuman objects, the suffering or humiliation of oneself or one's partner or children or nonconsenting persons that occur over a period of 6 months which cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Paraphilias listed on the DSM-IV TR includes exhibitionism, frotteurism, fetishism, pedophilia, sexual masochism sexual sadism, transvestic fetishism, and voyeurism [1].

The DSM-5 implemented various changes, in regard to the classification of the paraphilic urges, behaviors, and fantasies which includes eliminating the paraphilic behavior from the sexual and gender identity category and renaming it to its own category and establishing a difference between paraphilias and paraphilic disorder, the elimination of paraphilic disorder NOS, the addition of other specified paraphilic disorder and unspecified paraphilic disorder. The DSM-5 defines a paraphilia as any intense and persistent sexual interest other than genital stimulation, or preparatory fondling between phenotypically normal, physically mature, consenting human partners. Paraphilias may be indicative of sexual interest greater than or equal to normophilic sexual interests [2].

The criterion A for paraphilic disorders is defined as intense, recurrent sexual arousal that occurs over the period of 6 months. The Criterion B requires the person acting upon sexual urges with nonconsenting victims, i.e., voyeuristic disorder, exhibitionist disorder, frotteuristic disorder, and sexual sadism disorder, and has caused clinically significant distress or impairment in social occupational setting or other areas of

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functioning. The diagnosis of paraphilic disorder can be made if both Criterions A and B are met, thus the major differences between paraphilia and paraphilic disorder are the negative consequences of the behavior, including distress, impairment, or harm to others. Nevertheless, in pedophilic disorder, the element of the nonconsenting victim was not included. The newly added criterion C requires a minimum age of 18 years old for the diagnosis of voyeuristic disorder. Also, two new course specifiers were added; in full remission, 5-year duration and in a controlled environment (with the exception of pedophilia) [2].

The DSM-5 paraphilic disorders have been criticized due to problems with definition by exclusion, which pathologizes nongenital sexual arousal or sexual practices of consenting adults like sexual masochism, fetishistic disorder, and transvestic disorder, thus potentially increasing the false positives [3]. Another limitation with the DSM-5 definition is that it is based on culturally or individually specific criteria, minimizes the problems of non-consent (especially with pedophilic disorder) and there are a lack of field trials [4] and there is limited empirical data based on paraphilias. An additional issue with the new definition has to do with the interpretation of the DSM-5 in forensic settings. For example, an individual could be identified as having a paraphilic disorder based on sexual behavior, without taking into consideration the paraphilic arousal pattern [3] or the etiology of that behavior (substance-induced, frontal lobe injury, developmental disability, manic episode, neurodegenerative disorder), which could also lead to an increase in the false negatives [5]. In contrast, there are studies that show sexually criminal behavior unrelated to the sexual arousal pattern [6].

Assessment of Paraphilic Disorders

Evaluation of paraphilias includes a comprehensive examination including interview, sexual history, questionnaires, collateral information from records or informants, screening for

comorbid psychiatric disorders, and self-report. The first step involves getting informed consent from the patient, alerting him that the evaluative process may prove stressful, and advising him of the necessary limits of confidentiality regarding current or potential abuse situations. Patients should know that clinicians will be obligated to report information disclosed during clinical interviews, if "mandatory reporting" requirements apply [7]. While this may have an impact on the completeness of patients' disclosures to their clinicians during treatment, knowing state law and being able to communicate this clearly to patients during the initial evaluation is essential. The clinician must present him- or herself as willing to discuss patients' sexual issues openly. While it is the clinician's goal to establish rapport and to be receptive to sensitive material from any patient (particularly since many general psychiatric patients have sexual concerns and/or experience sexual side effects from medications), it is pivotal in this patient population. It is also important to remember that patients may habitually minimize or deny problematic behaviors, and may have significant cognitive distortions upon which they rely for rationalizing their behavior [8, 9].

Instead of focusing immediately on current paraphilic material, clinicians should start by inquiring about the patient's complete sexual history—paraphilic issues, non-paraphilic issues, childhood sexual experiences or activities, adult sexual experiences or activities, or lack thereof. This will help provide the clinician with appropriate background, instead of targeting paraphilic issues in isolation [10]. As noted earlier, patient's paraphilias may evolve over time in intensity, frequency, and area of desire [8]. Patients who engage in these behaviors may go on to re-offend and may escalate into more serious sexually offensive behaviors, including hands-on offenses. This emphasizes the importance of getting a full chronological history. It is likewise crucial to maintain a sense of nonjudgmental inquiry as the therapeutic alliance continues over time, so that any broadening of the patient's paraphilic repertoire is discovered and addressed in a timely and appropriate manner.

One approach in the assessment of sexual disorders is the four perspectives model—which includes disease, dimension, behavior, and life story. Each individual perspective contributes a distinct feature in formulating a comprehensive case, which still allows for being open to further information and, if necessary, further revision. The disease perspective focuses on the differential diagnosis, and categorizing the disease state, the goal of which is alleviation or cure. The dimension perspective is a measure of an individual's function, and focuses on an individual's relative assets and susceptibilities. This tactic highlights relative strengths, as well as develops strategies to avoid weaknesses. The behavior perspective is focused on goal-directed conduct. With problematic behavior, the objective of the behavior perspective is to interrupt or replace such actions. The fourth and final perspective, the life story perspective, is dependent upon the narrative from the patient, in order to give meaning and perspective to his or her life course. This perspective is utilized when one's life path appears to be taking a destructive turn, with treatment focused on reframing and reconstruction of a life narrative. This perspective is what many associate with psychotherapy, and employs a developmental focus [11].

Once a discussion of actual paraphilic activities has commenced, the clinician must ascertain the level of danger or risk related to the paraphilic behaviors. There may or may not be an immediate danger related to the behavior—for example, as in autoerotic asphyxiation and in some cases of sexual sadism or masochism. In sadism and masochism, the thrill associated with power differential and potential danger is often central to both the masochist's and the sadist's experience [12]. The danger may be benign and symbolic, but could be potentially lethal in actuality. In extreme cases of sadomasochism, where there is loss of control or confusion regarding the boundary between consent and coercion, behaviors can cause physical harm. It is the clinician's task to accurately decipher what is occurring in the sexual experience, on both overt and covert levels. What appears insignificant may hold key details of subtle sexual, intrapsychic, and relational

processes that comprise sadomasochistic interactions, which have gone awry. Only a detailed deconstruction of the partners' moment-to-moment interactions permits meaningful decoding of complex sadomasochistic experiences. Evaluation of danger applies to the other paraphilias as well. Once imminent risk has been explored and addressed if necessary, goals of treatment and various treatment modalities can be discussed.

Assessment Tools

While there are various subjective psychometric scales for patient assessment of sexual behaviors [8, 10], clinicians may or may not elect to use these during clinical evaluations. Objective tools and/or structured diagnostic scales also can be utilized in the evaluation of paraphilic patients. The most common objective tools are penile plethysmography, polygraphy, and viewing time of visual stimuli [9, 10]. These techniques have been most widely used in research and with sex offender populations, so their generalizability is unknown.

Penile plethysmography, also called "phallometry," involves measuring the patient's penile response to sexually stimulating material (audiotapes, still photos or slides, or videotapes). Stimuli may vary in content by age and by coercive vs. noncoercive content. Measurements are either taken of changes in penile circumference or changes in penile volume during stimulus presentation. Changes in circumference are recorded via a mechanical device, which the patient himself places on his penis. Changes in penile volume are more complicated, and are measured with the assistance of a technician who helps the patient with proper device placement [10]. Studies using phallometry have been done in male patients with pedophilia, biastophilia, and sexual sadism [13, 14].

Viewing time measurements attempt to draw conclusions between viewing time and specific areas of sexual interests [9, 10, 15]. The Abel Assessment for Sexual Interest (AASI)

is a version of viewing time assessments [9, 15]. This combines a self-report survey with measurements of visual reaction times to non-pornographic pictures of people of various ages. Validated assessment instruments have been reviewed including the interrater reliability of the DSM-IV, implicit association task (IAT), viewing time measure and picture association task, which evaluates pedophiles or child sexual abusers [16].

Self-report psychometric tools include the Multidimensional Inventory of Development, Sex and Aggressive behavior (MIDSA), the Multiphasic Sex Inventory (MSI), the Bradford Sexual History Inventory, and the Clarke Sex History Questionnaire for Males-Revised. The MSI is able to distinguish between the types of sexual offenders. The MIDSA, MSI, and SHQ-R assess sexual interests and behaviors [17]. The MIDSA is the most comprehensive as it also covers criminal behavior [14].

The Screening Scale for Pedophilic interests or SSPPI is a four item scale that assesses pedophilic interests such as male victims, more than one child victim, having a victim whose age is 11 years old or younger and having an unrelated child victim among convicted pedophiles and predicts sexual recidivism [14, 18]. The Child Pornography offender risk tool (CPORT) predicts recidivism among adult male sex offenders using child pornography [19].

Affinity 2.5 is a computerized assessment tool, which is based on explicit sexual attractiveness ratings of pictures from both genders combined with viewing time task, which found that pedophilic sexual offenders had higher ratings on attractiveness related to pictures showing small juveniles in explicit rating, as well as in viewing time measures [20]. Visual reaction time measures sexual interest based on how long the individual look at images that are sexually attractive to them. Studies have shown increased visual reaction time can predict recidivism among child sexual offenders [21]. Hempel found that implicit association tasks (IAT) could significantly distinguish between child sexual abusers and non-offenders [22].

Assessment Tools

Objective tools
- Penile plethysmography (phallometry)
- Polygraph
- Viewing Time of Visual Stimuli
  - Abel Assessment for Sexual Interest (AASI)
  - Implicit Association Task (IAT)

Self-report
- Multi-dimensional Inventory of Development, Sex, and Aggressive Behavior (MIDSA)
- Multiphasic Sex Inventory (MSI)
- Bradford Sexual History Inventory
- Clarke Sex History Questionnaire for Males—Revised (SHQ-R)

Screening scales
- Screening Scale for Pedophilic Interests (SSPPI)
- Child Pornography Offender Risk Tool (CPORT)

Computerized assessment tool
- Affinity 2.5

Laboratory Examination

Laboratory examination for paraphilias should incorporate a sexual hormone panel that includes free testosterone, estradiol, progesterone, follicle stimulating hormone (FSH), and luteinizing hormones (LH). Hormone levels are used to establish a baseline level and to screen for abnormal hormonal levels. It also helps to monitor the pharmacological interventions as the hormonal treatment of paraphilias goal is to reduce androgens like testosterone which influences sexual behavior and aggression. Some of these hormones might be helpful in predicting re-offense [14, 23].

Conclusions

In summary, the classification of paraphilia in DSM-IV TR refers to a group of conditions beyond usual love or attraction. As a group, the DSM 5 differentiates between paraphilias and

paraphilic disorders, with the major distinction being the level of distress or impairment associated with level of functioning. The evaluation process for paraphilias entails a comprehensive approach, comprised of a psychiatric interview, a longitudinal history, which includes a thorough sexual history. Additionally, collateral information, screening tests, questionnaires, and self-report are useful in assessment. There are various means of assessment utilized in the evaluation of paraphilic disorders, including objective tools, self-reports, screens, and computerized assessment tools. During the evaluation process, it is imperative to consider level of risk associated with paraphilic behaviors, while determining treatment goals.

Case 1: Denial of Erotic Arousal in a Man with Gender Dysphoria

A 37-year-old married man, father of two, sought treatment at a gender identity program with the chief complaint that he wished to become a woman. He reported that he had always felt like a woman but now wanted to transition to that role. He initially denied any fetishistic cross-dressing. His history revealed that he was an outstanding athlete and played football in high school before joining the Marines where he fought in the Middle East and rose to rank of sergeant. Married to his high school sweetheart he has two children. He also reported various extramarital affairs during his marriage but strongly disavowed any same sex interests or behaviors. He continued to masturbate fantasizing himself as a woman. Further history revealed that he recently had lost his business which he started after being discharged from the Marines and was facing serious trouble. After two visits he admitted that his cross-dressing was usually accompanied by extreme fetishistic arousal. Mental status examination revealed a major depressive disorder as well as his gender dysphoria and history of fetishistic cross-dressing. Treatment consisted of active antidepressant pharmacological treatment and supportive psychotherapy.

Comment: This patient initially presented with gender dysphoria and the wish to transition to phenotypic female

identity. More extensive evaluation found that the patient was a fetishistic cross dresser despite initial denial of any erotic arousal from wearing feminine clothes. Furthermore, his comorbid depressive diagnosis demanded treatment. The patient eventually chose to disavow his wish for gender transition and remain with his wife as a male. He continued to erotically cross dress in private.

Case 2: A Urinary Issue or Diaper Fetish?

A 29-year-old police officer was seen in psychotherapy for depression. After a few sessions he reported that he required wearing adult diapers due to urinary dribbling. On further questioning he admitted to erotic arousal when he wore such undergarments. The history then emerged that he had always fantasized being an infant and having his diapers changed by his mother. This reverie produced erotic arousal and he would masturbate to the fantasy. The therapy was directed towards the origins of such a preferred arousal pattern. Although the determinants of the paraphilic interest and behavior seemed to reside in his relationship with a distant mother his behavior continued despite enhanced understanding.

Comment: His initial reports of urinary tract issues were at best a rationalization to continue his fetish. Clinicians must be aware of such unusual complaints as a possible sign of a fetish.

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