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Diagnostic issues, multiple paraphilias, and comorbid disorders in sexual offenders: Their incidence and treatment

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Abstract

This paper critically appraises the criteria for DSM diagnoses of the paraphilias relevant to sexual offenders. It is concluded that these criteria leave a lot to be desired and that a more helpful approach would be to rate the features of each type of sexual offender along dimensions ranging from normal to seriously problematic. Next consideration is given to the evidence on the incidence of multiple paraphilias and comorbid disorders. It is not yet completely clear from this evidence that sexual offenders typically have multiple sexual outlets although some obviously do. What is clear is that incidence of comorbid disorders is sufficiently high to warrant concerns about how to effectively address these additional disordered aspects of sexual offenders in treatment. Finally, suggestions are offered about how to address in treatment both multiple paraphilic offenders and those with associated comorbid disorders.

Keywords: Sexual offenders; Diagnoses; Paraphilias; Multiple paraphilias; Comorbidity; Treatment

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Many clinicians are required by their job circumstances to apply a diagnosis to their sexual offending clients, while others deem it essential to the proper treatment of their clients. Researchers examining sexual offenders also typically use diagnostic descriptors, although they are not always careful to follow diagnostic criteria. In many cases researchers could easily use behavioral or legal descriptors (e.g., child molesters, rapists), but there are times in research (depending on the topic) when diagnoses should be applied. The problems in all these instances (clinical and research), are that some diagnoses may be inherently unreliable while others may be applied without due care. If diagnoses, rather than behavioral descriptors are to be used, then we need to examine in detail the relevant diagnoses and their associated criteria. The intention of this paper is to consider these issues in some detail and to offer an alternative approach. Diagnoses are, or should be, based on the careful application of criteria specified in one or another version of either the *Diagnostic and Statistical Manual* (*DSM*) of the American Psychiatric Association, the most recent version of which is DSM-IV-TR (American Psychiatric Association (APA), 2000), or the International Classification of Diseases, 10th Revision (ICD-10) (World Health Organization, 1992).

Research reports often use labels such as "pedophile" (describing some or all child molesters) or "sexual sadist" (describing those sexual offenders who are particularly brutal and who humiliate their victims). However, researchers frequently employ these terms without bothering to evaluate more precisely how many of the subjects meet DSM criteria. Further, some researchers (Freund, Scher, Chan, & Ben-Aron, 1982) distinguish pedophiles (those who molest prepubescent children) from hebephiles (those who molest post-pubescent children). It would clearly be preferable if all clinicians and researchers used the same terminology and DSM categories are but one option. This paper calls into question the assumption that the DSM provides a sound basis for a universally agreed upon nomenclature, particularly one that might guide assessment and treatment.

DSM-IV-TR (APA, 2000) lists some diagnoses that are relevant to persons who sexually offend. In this paper, consideration will be given to the value of the application of DSM-IV-TR criteria to various sexual offenders. The concerns will be how well the specific criteria guide diagnostic decisions and whether or not the diagnoses, so guided, are reliable. The latter question specifically concerns the likelihood that two or more independent diagnosticians will arrive at the same diagnosis.

Unfortunately for this endeavour, DSM-IV-TR, like its predecessors, does not have a category or diagnosis that is directly relevant to rapists, and many child molesters do not appear to meet diagnostic criteria for pedophilia. The authors of the DSM have consistently resisted pleas to have rape included (Abel & Rouleau, 1990). In terms of clinical practice, this has forced many clinicians to categorize persistent rapists as *Paraphilia NOS* (see Doren, 2002; Levenson, 2004). This solution is definitely not satisfactory as the DSM offers no criteria under *Paraphilia NOS* for diagnosing rapists, and it was likely not the intention of the DSM authors to have rape included in this catchall category. In fact, the authors of DSM-IV-TR, note under the chapter "Other conditions that may be a focus of clinical attention", that the nondiagnostic category *Sexual abuse of an adult* is the relevant descriptor for rape.

1. Reliability issues

Any system that attempts to classify any set of things (in this case human psychological problems) must, if it is to be useful, demonstrate that the allocation to categories can be applied reliably (Nelson-Gray, 1991). In the case of the DSM, the issue of primary concern is inter-rater reliability. Different clinicians evaluating the same client should arrive at the same diagnosis or set of diagnoses. This seems like a simple requirement that would be easy to test but it is not so simple as it appears. Ideally, to establish reliability across diagnosticians it would be necessary to: (1) have several clinicians evaluate the same person in several face-to-face examinations; (2) provide them with the same information (e.g., test results, history); and (3) allow them to interview family and friends of the client. This would obviously be an expensive and somewhat daunting undertaking.

The authors of DSM have, over the years, conducted field trials in an attempt to estimate interdiagnostician reliability. Essentially, these field trials involve providing several known experts in the field of concern (e.g., paraphilias, depression, anxiety, personality disorders) with extensive information (including videotaped interviews) on the subjects to be diagnosed, and have each clinician independently arrive at a diagnosis (for details see *DSM-IV Sourcebook*, *Vol. 3*, APA, 1997). Since each of the diagnosticians is aware that the DSM committee will be examining their decisions and comparing them with the decisions of other diagnosticians, the resultant reliability estimates are likely to be inflated, compared with routine clinical diagnoses, as a result of the extra care taken by each clinician. In addition, it seems unlikely that the DSM committee would select ambiguous cases for this appraisal, with the result again being a likely