

THE CLINICAL ASSESSMENT OF SEXUAL DISORDERS*

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INTRODUCTION: There has been a growing concern regarding false allegations of sexual abuse especially those arising during custody studies. These troubling allegations can have a significant impact upon an individual's ability to have adequate visitations with family members, especially younger children. In some cases, the accused is prohibited from having any meaningful interactions with minors until the unfounded allegations are resolved. These allegations often arise during disturbed communications between a couple attempting to resolve their divorce and related custody issues. These disturbing clinically dynamics are found within the context of the Parental Alienation Syndrome and have been addressed in detail by Dr. Richard Gardner and other notable clinicians. In addition to the Parental Alienation symptom, some falsely accused individuals are misdiagnosed by zealous and well-intentioned clinician who imprudently discovers a non-existent sexual disorder based on innuendos and prejudicial information provided by biased parties.

In other cases, some parents are not allowed to live with their immediate family when they have been accused of an out of family sexual crime. In other words, the court or a social agency tells the accused that they cannot have any contact with their immediate family because they sexually offended a non-family member. It is implied that similar sexual crimes will occur at home. Sexual offenders who commit sexual offenses in the community do not necessarily replicate the same type of sexual offenses at home. It is important to note that sexual offenders who commit sexual crimes outside of the family do not necessarily commit a sexual crime at home with their spouse or children. Systematic and comprehensive evaluations are an important way of responding to these concerns. A sound clinical assessment can provide the court with valuable information regarding the existence of a sexual disorder and what treatment approaches will be beneficial if a sexual disorder is present. These assessments can also be used to refute false allegations arising in disputed custody cases and when elements of the Parental Alienation Syndrome are present.

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ASSESSMENT GUIDELINE CHECKLIST

The following clinical procedures can be employed in a clinical assessment designed to verify the existence of a sexual disorder.

1. Structured Clinical Interview-Utilize Multiple Sources of Data: Mental Status, Psychological Testing, Review relevant documents including victim statements.
2. Assess Level of Psychopathology-provide diagnosis where applicable and include remedy in treatment plan.
3. Assess Psychopathic tendencies and utilize PCL-R where appropriate
4. Assess for Substance Abuse
5. Assess Psychosocial Adjustment and Marital History
6. Cognitive Assessment as needed
7. Make Assessment of Level of Sexual Deviance through a combination of self-report, history, and Plethysmography Assessment
8. Provide Assessment of Risk utilizing available actuarial tools
 - a. Consider both Static and Dynamic variables
 - b. Outline a plan for managing risk in accord with disposition
9. Amenability for Treatment
 - a. Assess Attitude and Likelihood of Compliance
 - b. Recommend Where Treatment Should Occur
 - c. Outline a Treatment Plan when appropriate
10. Indicate if Elements of the Parental Alienation Syndrome have been observed.
 - a. Recommend what additional steps should be taken to resolve distorted perceptions and dysfunctional relationship conflicts.

In a number of cases, people accused of sexual crimes will totally deny these allegations because they have not committed the alleged crimes. In some of these cases, the allegations are actually false and have been made for a variety of reasons (Ney, 1995.) It appears that the most common type of false allegation occurs during acrimonious custody disputes or when inappropriate interviewing techniques are utilized during an unstructured interview. A critical analysis of these types of strategic interviews and related dilemmas has been provided elsewhere. (Ceci, S. and Bruck, M., 1995, Poole, D. & Lamb, M., 1998.

The following historical factors should be taken into consideration during an assessment of this nature.

Psychopathology and Mental Illness

There is no one psychiatric condition associated with all sexual disorders. Except in rare cases, psychiatric illnesses such as an affective disorder or a psychosis do not directly cause the sexual offenses. The population of sex offenders is quite heterogeneous. It is very important to screen for underlying psychiatric disorders in any assessment since untreated conditions could sabotage treatment or make it less effective. However, there are some psychiatric conditions, which might relate directly to the person's sexual offense.

A thought disorder or delusional state at the time of the offense has both significant legal and treatment implications. In most cases, however, psychiatric status is usually important in determining ability and likelihood of complying with treatment and probationary guidelines. In our clinical experience, most individuals lose their probationary status not because of sexual recidivism but for non-compliance with treatment or other probationary guidelines, such as a supervised contact with a minor. However, if certain mood states, personality disorders, major thought disorders or substance abuse is associated with the offending, then certainly these concerns need to be evaluated and discussed in the assessment report. In addition to exploring the individual's own recollection of psychiatric treatment, a review of relevant records and reports could be of major assistance.

Substance Abuse:

Individuals clearly need to be screened for the presence of substance abuse or alcohol issues. Such abuse may have played a more or less significant role in the individual's offense. In most cases, it reduces the individual's inhibitions and allows him to more easily broach boundaries to sexual offending. In addition, substance abuse or alcoholism clearly blocks a person from benefiting or appropriately participating in treatment

Criminal History:

A detailed review of criminal history is directly relevant. This history should include both adolescent and adult violations. Access to information apart from self-report can be very important. Obviously, any prior sexual offense is directly relevant to recidivism risk. In addition to such prior offending, any history that the individual violated a prior probationary sentence is also significant. Some sexual offenders claim not to recall their previous criminal history. The official arrest and conviction records should be obtained through the appropriate legal channels. In some cases, legal counsel will fail to provide these important records. In many jurisdictions, juvenile records are difficult to obtain. The seasoned clinician will demand to review these very relevant records before finalizing his or her report. It is extremely alarming and disarming in court when opposing counsel or the judge questions why you did not review an array of legal documents that could totally change your clinical conclusions. The clinician should document their request to obtain these valuable materials.

Psychosocial Adjustment:

As with any clinical assessment, the psychological assets and deficits of each individual need to be carefully assessed when community safety issues are of concern. A review of the person's social and marital history can provide information relevant to his ability to adequately function in the community. A pattern of short-term unstable relationships could also be a warning sign of serious personality deficiencies and/or the selection of dysfunctional adult partners. Any of these factors, for different reasons, could contribute to future risk.

Family History:

A thorough review of family history is important for identifying behavioral disorders and early traumas. Being a victim of either sexual or physical abuse can put a person at risk for a variety of adult disorders. Fortunately, most people who are sexually abused do not go on to sexually offend others. Family support and treatment intervention at the time of the discovered abuse can reduce the likelihood of more serious emotional and behavioral psychopathology. However, the presence of previous sexual abuse could play a significant role in offending and reoffending. Some abuse victims may manifest chronic boundary problems because of their early childhood experiences. Some of our more chronic sexual offenders were victimized by a number of perpetrators. Through these experiences, they believed that these abusive patterns were unspoken forms of normal sexual development. These issues of ongoing trauma need to be addressed in treatment.

School and Vocational History:

Poor school adjustment can be an indicator of either an underlying learning disability, poor motivation and/or an ongoing behavioral disorder. Individuals should be questioned concerning their ability to pay attention and stay seated while in elementary school. Attention Deficit Hyperactivity Disorder is recognized as a mental health disorder, which may continue into adulthood. It has been identified as a risk factor for delinquency and substance abuse. However, ADHD has **not** been directly identified as a primary cause of sexually abusive behavior. It may be a factor in generalized impulsivity. Caution is needed, since in some cases children with PTSD have been misdiagnosed as ADHD.

Sexual History

A comprehensive review of an individual's sexual history is relevant when seeking to identify the presence of paraphillias as described in the DMS-IV-TM. Admittedly, most sex offenders are not open on initial contact to revealing these issues in any detail. However, a basic historical review should occur in order to lay the groundwork for further exploration in these areas. Some individuals will reveal a history of deviant sexual thoughts, which they may or may not have acted out previously. Some sexual offenders will acknowledge pedophilic thoughts and behaviors. Paraphillias such as voyeurism, exhibitionism, frotteurism, sadism, and masochism should be addressed. A history of involvement with prostitutes and pornography should also be explored. Recently, with explosion of the Internet, many more people are becoming preoccupied with pornography through this source (McGovern and McGovern, *** These preoccupations, although not necessarily illegal, can clearly disrupt the individual's ability to function adaptively in such social contexts as a marriage or a job. During the course of an assessment and treatment, individuals will be given further opportunity to divulge any troubling sexual fantasies and behaviors. At some point, they may be asked to complete a full disclosure polygraph especially if ordered to do so by the court or a probation officer. In some cases, sexual offenders have needed to complete these types of polygraph on a number of occasions and have not been able to successfully pass them.

This process can go on for many months or even years depending upon the tenacity of the probation officer.

While taking a sexual history, it is extremely important to unravel how early sexual arousal patterns, fantasies and masturbatory behaviors emerged. Questions should be asked regarding an individual's sexual educational experiences and acquired myths regarding human sexual functioning. Cognitive distortions about the nature of sexual abuse can encourage the fostering of deviant fantasies. One offender in treatment had long harbored a fantasy of awakening the sexual interest of a less experienced female. His fantasy life became partially focused upon younger females as a part of this fantasy and when given the opportunity acted this out with a minor relative. Prior to treatment he had not considered how this fantasy put him at risk for sexually abusive behavior. Rather than seeing the broader context of this minor females experience his fantasy and perceptions distortions encouraged a narrow self focused view of his victim.

The primary purpose of obtaining a sexual history is to contrast the usual and customary sexual preferences of an individual with their current offense patterns. This self-report history should also be verified with other collateral information. For example, a sexual offender may report that this is his first victim and that the sexual act was uncharacteristic of his or her sexual demeanor. A polygraph examination may imply that the sexual offender may not be providing an accurate historical description of his sexual behavior. These results may also reveal that the sexual offender has previous incidents with other siblings. Further inquiry with family members may also reveal that the sexual offender has had previous problems with public indecency. In addition, other complaints have arisen by previous girlfriends or wives about assault sexual behavior. Obviously, this collateral information could modify the clinician's initial perceptions regarding the extent of this individual's sexual disorder.

Polygraph examinations

Over the last decade, greater emphasis has been placed on the utility of polygraph examinations during both the assessment and treatment of sexual offenders (Abrams & Abrams, 1993). Polygraph examinations are now being used in three ways. Initially, it is not uncommon for an accused sexual offender to take a polygraph examination regarding the pending claims of sexual misconduct. Since most sexual offenders initially deny their sexual crime, some mental health care providers, attorneys, and police officers want to verify whether the claimed allegations are valid complaints. In some cases, the accused successfully pass a polygraph examination and may be victim of a false allegation.

Secondly, polygraph examinations are also used in order to verify the veracity or truthfulness of an individual's sexual history. Although there is ongoing controversy regarding the validity of these examinations, some polygraphers profess that full sexual history polygraph examinations are valid and can provide the examiner with valuable information regarding a person's sexual history. Prior to these polygraph examinations, the sexual offender provides a detailed written sexual history. They are then asked whether or not they are providing the polygraph examiner with accurate information.

There appears to be a higher rate of false positives during the administration of these polygraph examinations. In addition, some polygraphers refuse to administer polygraph examinations in this fashion. We find that these techniques are more likely to provide accurate histories after the individual has been in treatment than if they are administered before treatment. Further scientific research is needed in order to determine the degree to which full sexual history examination polygraphs are valid.

Thirdly, polygraphs are also used in order to determine whether or not a person is complying with the guidelines established by the court. Individuals are asked whether they have had unsupervised contact with minors or committed other sexual crimes over a specific period of time. These polygraph examinations are often given periodically during the course of an individual's outpatient therapy and probation. The results of these polygraph examinations are used as a guideline regarding an individual's ability to conform to community safety standards. If an individual fails a polygraph examination of this nature, these results often lead to closer monitoring, or in some cases, to a probation violation or another arrest.

Neurological Impairments

Clinicians should also determine whether or not a comprehensive neurological examination is necessary, especially when a person appears to demonstrate a number of clinical symptoms including learning problems, memory losses, head trauma, fetal alcohol symptoms, and the neurological problems caused by other medical causes. Neurological and neuropsychological examinations may establish the presence of diffuse or chronic brain damage. These clinical considerations must be carefully scrutinized. If a major organic impairment arises during an evaluation, the clinician needs to determine whether these deficiencies will lead to other forms of impulsive, sexual behavior in the future. Further consideration could be given to whether or not medication will be a necessary tool to assist in the control of the sexual disorder.

ASSESSING PSYCHOPATHOLOGY AND MENTAL DISORDERS:

Various methods of assessment can be of assistance in determining an individual's psychiatric status. A thorough mental status examination during the course of obtaining a history can be quite valuable. Clinicians can also validate their initial impressions by utilizing the objective personality inventories, standardized questionnaires and projective tests used in clinical and forensic assessments (Graham, 2000).

Minnesota Multiphasic Personality Inventory-II

The recently revised Minnesota Multiphasic Personality Inventory-II is one of the most commonly utilized, standardized psychological tests. Exhaustive research on this instrument has demonstrated that there is no one testing profile indicative of a sexually abusive individual (Vien, 1988). There is no one-personality type consistent with sexually abusive behavior, however, such testing can be important in assessing personality characteristics such as impulsiveness, major personality disorders, paranoia

and chronically poor judgment. This instrument can also assist in identifying the presence of a psychiatric disorder. The presence of such a disorder in this population can have implications for amenability to treatment. Such co-occurring disorders need to be addressed and treated simultaneously with the sexual disorder.

One of the unique and powerful features of the MMPI-2 is the presence of what are termed validity indicators. During forensic assessments, the possibility of dissimulation is quite high. Some offenders will either deny or minimize the extent of their behavior and deviant arousal patterns. Relative elevations on these scales reveal the test takers attitude toward the test. It may also reflect his general approach to the assessment and his subsequent sexual arousal responses during a penile plethysmograph evaluation (Brewer, 2000). Individuals who are attempting to present an overly positive image of them may show significant elevations on certain of the K and L scales. Such elevations should lead an evaluator to be even more cautious in his or her assessment. Although rare, some offenders may attempt to present as more disturbed than they are. An extreme elevation on Scale F would be one sign of such an attempt to malingering in a negative direction. Many sexually abusive individuals will present with normal appearing profiles on a broad range of inventories. In many cases, there is no evidence of other psychiatric disorders. In our experience, most sex offenders do not have co-occurring psychiatric disorders except for depression and anxiety caused by the immediate arrest.

Results from this personality inventory allow for the generation of hypotheses, which can be explored during other aspects of the assessment process. Answers to certain questions can be explored with the individual during a follow up interview further clarifying the presence of a psychiatric and/or personality disorder. In addition, questions can be asked regarding the respondent's answer to critical items such as anger, paranoia and suicidal ideation. It is not uncommon for convicted sexual offenders to consider suicide especially when the court is likely to recommend long-term incarceration.

The Millon Clinical Multi-axial Inventory-III

This Inventory developed by Theodore Millon (1997) was most recently revised into a third version. Millon has continued to upgrade and refine this instrument over the last few decades. There were two prior versions. It is one of the few psychological inventories designed to assess for the presence of a personality disorder, which has implications for the treatment of a sexual offender.

Millon has cautioned that this instrument has been normed with a psychiatric population and should be used only on individuals who are likely to have significant psychiatric and interpersonal problems. It is not meant to be used with a normal population. To our knowledge there are no norms relevant to sex offenders. Rogers (1999) has written a critical review of this inventory and suggested that it does not meet standards for use within a forensic setting.

As with other psychological tests, inventories or questionnaires, we recommend their use as a tool to generate working hypothesis and clinical impressions regarding each specific

individual evaluated. Concerns about a possible personality disorder can be explored further with interviews and additional psychological protocols including projective testing.

Psychopathy Checklist:

Research has indicated that psychopaths are at heightened risk for recidivism not only for crimes in general but also for sexual offenses (Quinsey et. al. 1998). True Psychopathy is a fairly rare condition even within the general. In general, these character disorders are found in approximately 1% of the general population. A higher rate will be found among convicted and incarcerated offenders. Major personality disorders are not commonly found in outpatient settings. If the evaluator has reason to suspect its presence from the person's past history then the administration of the Psychopathy Checklist-Revised (PCL-R) is advised (Hare, 1991).

The PCL-R is divided into two sections each focusing on a different component of the Psychopathy construct. Personality characteristics such as a lack of empathy and grandiosity can be observed during the course of interviewing and history taking. A second component, which is more dependent upon history and a review of records, includes items such as a history of impulsiveness and irresponsibility. Administration of this instrument may be called for in cases where Psychopathy is suspected especially when evaluating the sadistic and/or violent sexual offender.

The PCL-R is considered the definitive instrument for identifying the presence of this disorder and scores on this instrument have been significantly related to recidivism amongst some sex offenders. In fact, high levels of Psychopathy on this instrument have been related to higher recidivism for the criminal population as a whole. In addition, treatment with psychopaths is of questionable efficacy. As noted earlier, some have suggested that certain forms of treatment may actually make them worse (Quinsey, 1998).

Projective Measures:

Projective measures such as the Rorschach and the Thematic Apperception Test may sometimes be useful for eliciting sexual pre-occupations or themes in the individual's life. If such preoccupations are found it should trigger a more detailed inquiry. These projective instruments may also allow for a closer assessment of the individual's thought processes and the presence of a psychosis or fixated sexual preoccupations. This type of content analysis can be done in conjunction with more significant sophisticated scoring systems such as that provided by Exner (1999) with the Rorschach.

Sexual History Protocols:

A number of helpful protocols have been created to provide more concise information regarding an individuals' sexual history and preferences. For example, the Multiphasic Sex Inventory-II (Nichols and Molinder, 1984) is a self-report questionnaire, which

provides information regarding a person's willingness to identify their sexual problems. This standardized questionnaire provides objective scores and validity scales. This information can be used to generate hypothesis about an individual's normal and deviant sexual functioning. This instrument measures sexual deviance, sexual dysfunctions, sexual knowledge, atypical sexual behaviors, cognitive distortions and motivation for treatment.

The Sone Sexual History Form (ASA, 2002) is a fourteen-page questionnaire that provides a series of questions regarding a person's early developmental experiences, adolescent sexual involvements, and an individual's current sexual life style as an adult. This protocol also includes a section pertaining to the sexual offenses. Although there is no formalized scoring system, the information obtained from this instrument can be cross-referenced with data obtained from the clinical interviews, polygraph and plethysmography assessments.

ASSESSING SEXUAL INTEREST AND AROUSAL

Plethysmography

Nothing seems more evident than the role of sexual arousal in the commission of a sexual offense. However, most sex offenders evaluated at our clinic are not pedophilic in their sexual orientation and/or measured arousal patterns. The most common method for assessing sexual interest has been the plethysmograph. The plethysmograph involves the systematic charting of an individual's penile engorgement in response to various sexual stimuli. There is a significant literature addressing the validity of arousal assessment in discriminating offenders. However, significant issues have also been raised about norms for stimulus materials and the impact this could have upon reliability. Others have argued that the utilization of this assessment in the proper contexts can lead to reliable and discriminating findings. Both visual and auditory stimulus materials are commonly used during this assessment. In our clinic these stimulus materials are administered independently. The individual is asked to view a series of slides. Following this he is then asked to listen to a series of sexually explicit audiotapes. These scenarios include themes of normal consensual sexual encounters followed in a systematic way by tapes of gradually increasing coercive themes. Audiotapes of this type have most often been used to determine if an individual is aroused to coercive and rape oriented themes.

Recent research in our clinic has determined that participants are more likely to respond at a higher level to audiotape materials than the slides (Thompson, 2000). Clinicians utilizing these phallometric assessments should consult with their local District Attorney's Office to determine if current laws prohibit the use of aberrant visual sexual materials in a clinical environment. The Association for the Treatment of Sexual Abusers (2001) also cautions the clinician about this concern regarding the use of aberrant visual materials defined as child pornography.

Whatever the results of an arousal assessment, it does not allow one to conclude that an individual has or will engage in a sexual assault. A significant number of individuals, approximately thirty percent who are assessed on this instrument at out patient clinic, do not show significant arousal to any of the material. In addition, there is research indicating that individuals can modify their response to the assessment thus masking deviant arousal. Plethysmography assessments are more likely not to identify deviant sexual arousal. Those who deny sexual offenses are more likely to be non-responders.

In any case, positive indications of arousal to deviant material are worthy of concern and may assist the individual in being more forthcoming about their arousal issues. Additionally, deviant arousal is another important factor for risk assessment. Research has indicated that extra-familial child sex abusers are more likely to manifest arousal to child stimuli on the plethysmograph than are incestuous child molesters. This appears consistent with research indicating that extra-familial abusers are also at higher risk for re-offending. The results of any sexual arousal assessment must be carefully interpreted because of these and other related issues. Arousal responses measured through plethysmography do not infallibly establish that a sexual offense did or did not occur.

Abel Assessment for Sexual Interest

A more recent instrument, which has been reported to sometimes correlate with plethysmography, is the Abel Assessment for Sexual Interest (Abel, 1995 & Abel et. al, 2001). This instrument purportedly measures sexual interest and not arousal by measuring an individual's visual reaction time to a series of systematically presented pictorial materials. These slides portray a broad range of age groups of both sexes. They also portray several categories of sexual paraphillias including exhibitionism, voyeurism, fetishism, frotteurism, and sadism. None of the slides include nudity. Additional information on history through a questionnaire is obtained prior to administration of the stimulus materials. The individual is in voluntary control of how long he wishes to view the slide and gives a rating of his subjective arousal to each slide. The subjects viewing time is automatically recorded by the computer. It has also been claimed that this instrument has high correlations with plethysmography. However, there has been recent criticism of the statistical properties of this instrument suggesting that individual scores cannot be compared to group norms. Criticism of resulting validity has been made (Fischer & Smith, July 1999). Further research exploring this technology is needed.

CONCLUSIONS:

This paper has focused on the assessment of sexual disorders and related legal issues. As stated previously, some individuals are wrongfully accused of sexual offenses during acrimonious separations and heated divorces. These allegations can lead to very serious legal consequences, including incarceration and long term separations from loved ones. A comprehensive psychological assessment can, in some cases, be very beneficial in identifying other factors that may have lead to an erroneous diagnosis, especially when elements of the Parental Alienation Syndrome are present. In a number of cases, the allegations of sexual misconduct have emerged because of inappropriate interviewing

techniques and the biased observations of well intentioned clinicians who misdiagnose a sexual disorder without adequate information. These diagnostic errors can lead to hyper vigilance and distorted perceptions. These assessments can also be utilized to determine who has been accused of a sexual crime presents an immediate risk to his immediate family. Although a person may engage in deviant sexual behavior with a non-family member, it does not mean that he will engage in similar types of sexual behavior at home with immediate family members. This is true of both adolescent and adult sexual offenders.

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