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Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Sexual Behaviour and Risk of Sexual Offending

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STATEMENT OF INTENT: CAPL Resource Guide for Reference and Training

This document is intended as a review of legal and psychiatric principles to offer practical guidance in the performance of forensic evaluations. This resource document was developed through the participation of forensic psychiatrists across Canada, who routinely conduct a variety of forensic assessments and who have expertise in conducting these evaluations in various practice settings. The development of the document incorporated a thorough review that integrated feedback and revisions into the final draft. This resource document was reviewed and approved by the Board of CAPL on March 31, 2022. It reflects a consensus among members and experts regarding the principles and practices applicable to the conduct of forensic assessments. This document does not, however, necessarily represent the views of all members of CAPL. Further, this resource document should not be construed as dictating the standard for forensic evaluations. Although it is intended to inform practice, it does not present all currently acceptable ways of performing forensic psychiatry evaluations and following these guidelines does not lead to a guaranteed outcome. Differing facts, clinical factors, relevant statutes, administrative and case law, and the psychiatrist's clinical judgement determine how to proceed in any individual forensic assessment.

This resource document is for psychiatrists and other clinicians working in a forensic assessor role who conduct evaluations and provide opinions on legal and regulatory matters for the courts, tribunals, and other third parties. Any clinician who agrees to perform forensic assessments in any particular domain is expected to have the necessary qualifications according to the professional standards in the relevant jurisdiction and for the evaluation at hand.

See the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles, which apply to all the guidelines and will not be repeated below. See also the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Violence Risk Assessment and the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Dangerous Offender/Long-Term Offender.

OVERVIEW OF SEXUAL BEHAVIOUR AND RISK OF SEXUAL OFFENDING

The area of sexological assessments is complex due to the evolving understanding of the field and the variability

in assessors' approaches to the topic. Therefore, this guideline begins with an introduction to the field to provide the assessor with a broad outline of the concepts and risk management strategies, forming the foundation for the assessment and report writing sections.

Introduction

The assessment of sexual behaviours and sexual offending is a core skill of forensic psychiatrists. Although sexual offending is often included in assessments of violence risk more generally, there can be important differences in the motivations, context, and victims of sexual violence. It is necessary to know and understand the variables related to sexual offending to assess risk in this area. Data from empirical studies can inform decision-making regarding the treatment and risk management of sexual offenders. Assessments of problematic sexual behaviour, sexual offending, or paraphilias can occur for various reasons, including understanding the nature, extent, and motivation of the sexual behaviour; exploring criminogenic needs; identifying treatment options; and providing a risk assessment and identifying risk management interventions. (1) Sexual behaviour assessments can take place in a criminal or civil context.

Sexual assault is defined as nonconsensual sexual contact. An exception is "statutory" rape or sexual assault, where it has been decided by the particular jurisdiction that people below a certain age are incapable of providing the requisite consent. The prevalence of sexual offending is difficult to ascertain, as many sexual assaults are unreported, many offenders are never apprehended or charged, and many charges do not result in conviction. (2–5) Most victims of sexual assault are female, and most perpetrators of sexual assaults are males known to the victim, most commonly as an acquaintance, family member, or current or ex-partner. (5)

Sexual Preference and Behaviour

To identify aberrant sexual interests and behaviour, forensic assessors must first be aware of what are considered normophilic sexual interests and normative sexual behaviour. The definition of normative sexual behaviour has changed over time, being largely defined by society. Several factors are relevant to societal perceptions as to whether sexual behaviour is to be regarded as anomalous, (6) including the presence and definition of consent, frequency of the behaviour, location, age of those involved, and any related harm. In some cultures, normative behaviour includes masturbation, oral sex, anal intercourse, and sex before marriage; in other cultures, these may remain taboo. Some sexual behaviours are societally condemned and legally prohibited in almost all modern jurisdictions, such as incest, sexual behaviour with a child, and rape.

Society often defines normophilic sexual interests narrowly and conservatively, but evidence suggests that human sexual behaviour has a broad range of expression, interests, and prevalence, including behaviours considered unacceptable or immoral in some societies or cultures. Although criticized for being focused on high-income countries and not necessarily generalizable, the literature highlights this diversity. For example, the release of the Kinsey Reports around 1950 shattered conservative views of human sexuality. The Kinsey Reports include two books: *Sexual Behaviour in the Human Male* (1948) (7) and *Sexual Behaviour in the Human Female* (1953). (8) They are based on personal interviews with subjects on various topics related to sexual behaviour, including factors such as age, social-economic status, and religion.

Subsequent population surveys on sexual behaviours have aimed to understand the frequency and types of behaviours considered to be normative over time. (9–13)

Paraphilias

Around the end of the 19th century, psychiatrists' description of anomalous sexual interests and activities began the overarching framework of paraphilias as a medical phenomenon. In 1886, von Krafft-Ebing published *Psychopathia Sexualis,* (13) a description of over 200 cases of paraphilic behaviour or interests, including sexual murder. Aberrant sexual behaviour was conceptualized as a moral condition, and treatment included abstinence, castration, incarceration, or death. Von Krafft-Ebing described four sexual neuroses: anesthesia (failure to be excitable), paradoxia (sexual excitation while not engaging in sexual activity), hyperaesthesia (excessive sexual excitation in response to stimuli), and paraesthesia ("perversion of the sexual instinct," including sadism, masochism, fetishism, and antipathic sexuality [homosexuality]). Sexual deviations were defined as any sexual activity that did not contribute to procreation. (14) In 1913, Kraepelin described the case of a man with pedophilic interests. (15) Freud detailed anomalous sexual interests and activities through his early theory of sexuality, including an emphasis on sexual development as well as biological factors. (16)

A paraphilic interest involves sexual arousal to specific objects or situations that others may see as "kinky" or unusual. Literally translated, paraphilia means "love" (philia) "beyond the usual" (para). Historically paraphilias were referred to as perversions.

According to *The Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition* (DSM-5), the central issue in paraphilic disorders is that sexual arousal depends on interests that are detached from a reciprocal, consenting adult partner. (17) There may be themes of aggression, violence, hostility, or impulses to engage in sexual behaviour with unwilling or nonconsenting individuals. A paraphilic interest may elevate to a paraphilic disorder if it causes significant dysfunction or interferes with the rights of others. Compulsion and lack of flexibility might also be important features of paraphilic behaviours. People with paraphilic interests may feel driven to engage in certain acts that might

personally degrading or harmful to others, even when these interests lead to illegal activity or are unacceptable to others.

Sexual arousal depends on multiple factors, including age and neural, hormonal, genetic, cultural, and contextual variables. (6) The etiology of paraphilias remains unclear, and the causes are likely multifactorial. Biological variables that likely contribute are hormones and neurotransmitters, including testosterone, serotonin, dopamine, and estrogens and their actions on multiple brain regions and erogenous zones. Many psychological theories of the etiology or development of paraphilias have also been hypothesized. A summary of this literature is beyond the scope of this guideline.

The DSM-5 distinguishes between a paraphilia and a paraphilic disorder. (17) Eight identified paraphilic disorders describe recurrent and intense sexually arousing fantasies, urges, or behaviours occurring over at least six months and typically involving nonhuman objects, suffering or humiliation, or children or other nonconsenting partners. There are also residual categories of "other specified paraphilic disorder" and "unspecified paraphilic disorder." Some specifiers are identified for each paraphilic disorder. The DSM-5 identifies paraphilic disorders by two main criteria:

1. Criterion A—the qualitative nature of the paraphilia
2. Criterion B—the negative consequences of the paraphilia (distress, impairment, harm to others)

Paraphilias can be exclusive (the person is not aroused by anything other than their paraphilic interest) or nonexclusive. The current balance of evidence would suggest that paraphilic arousal is unlikely to change because it often begins early in life and appears to be stable. (18) Sexual behaviours, however, can change over time. This could be based on opportunity, having diverse sexual interests (a nonexclusive paraphilic interest), treatment, age-related factors, and the impact of social censure and related population variables.

As noted in the DSM-5, paraphilias may be seen as anomalous courtship processes in males. (19) Recognizing that the DSM-5 does not offer an exhaustive description of all anomalous sexual behaviours, it provides two broad categories of the more common paraphilic disorders: anomalous activity preferences and anomalous target preferences.

Regarding anomalous activity preferences, certain paraphilias are seen as courtship disorders in males, which resemble distorted components of human courtship behaviours. (17,18) The phases of courtship, and the associated paraphilias when disruption occurs in each of these phases, are as follows:

- Voyeurism: locating and appraising a potential partner
- Exhibitionism: pre-tactile interaction (smiling, showing, talking)
- Frotteurism: tactile interaction (embracing, petting)

Of note, Freund and Blanchard also described preferential rape as the distortion of genital union in the courtship process. (19) the DSM-5 categorizes anomalous target preferences as those directed at other people (e.g., pedophilic disorder) and those directed elsewhere (e.g., fetishistic disorder).

Individuals often have more than one paraphilic interest, highlighting the need to assess for multiple paraphilias. Hall and Hall estimate that 50% to 70% of people with a pedophilic sexual interest have another paraphilia, with 30% of those with pedophilia identifying exhibitionism as another paraphilic interest (20,21). Some paraphilias tend to cluster together. Those with a coercive or sadistic preference may have co-occurring masochistic, voyeuristic, exhibitionistic, and (or) transvestic interests. (22) There may also, for example, be a progression of paraphilic behaviours over time within the coercive spectrum. (23) Although extremely rare, there may be a further progression to sexual murder. (24)

Each paraphilic disorder is described briefly below. If the interest does not cause dysfunction or distress or impede the rights of others, it would be identified as a paraphilia and not a paraphilic disorder.

Voyeurism

Voyeurism is the recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, as manifested by fantasies, urges, or behaviours. (17) This is colloquially called "peeping" and is for the purpose of sexual excitement; no sexual activity with the target person is sought. The onset is usually before age 15, with an associated high frequency of voyeuristic acts much higher than the rate of detection. (25) Electronic devices to surreptitiously record victims can be employed. A critical part of the assessment of an individual with voyeurism is to assess for other paraphilias and rape planning, including the presence of paraphernalia that may be used to engage in sexual assault. Around 20% of voyeurs have been found to have committed a sexual assault, (26) highlighting the need to assess for potential progression to hands-on offences in those with voyeurism. Alternatively, some offenders charged with sexual assault engage in voyeuristic behaviours for the purpose of finding a victim rather than being motivated by the act of voyeurism itself.

Exhibitionism

Exhibitionism is the presence of recurrent, intense, sexually arousing fantasies, urges, or behaviours involving exposure of one's genitals to an unsuspecting person. (17) Sometimes, the individual masturbates while exposing themselves; typically, there is generally no attempt at further sexual activity with the stranger. A specific emotional reaction may be sought, such as fear, admiration, anger, or disgust, or the individual may fantasize that the target would want to show

their genitals or engage in sexual intercourse. (27) Onset is usually before age 18; the frequency of engagement in the behaviours tends to be higher than other paraphilias, and re-offenders are often undetected. (28) Few arrests are made in older age groups, and it is uncommon after age 40, unless associated with disinhibiting factors, such as a neurocognitive disorder or pedophilia. (27)

Frotteurism

Frotteurism is the presence of recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving touching or rubbing against a nonconsenting person. (17) Toucherism is the term used when a person touches others with their hands. Frotteurism is when a person touches others with another part of their body (most often their genitals). The behaviour usually occurs in crowded places from which the person can easily escape arrest. The individual usually fantasizes about an exclusive, caring relationship with the victim and engages in an average of 800 acts. The majority of frotteurs have a comorbid paraphilic disorder (such as exhibitionism and voyeurism). (22) Most acts occur between the ages of 15 and 25 years, with an onset in adolescence.

Fetishism

Fetishism is the presence of recurrent, intense sexually arousing fantasies, urges, or behaviours involving the use of nonliving objects or a highly specific focus on nongenital body part(s). (17) The objects aren't limited to articles of clothing used in cross-dressing or devices specifically designed for the purpose of tactile genital stimulation. The fetish is usually required for sexual excitement, and the person may experience erectile dysfunction in its absence. It usually begins by adolescence, although the fetishist may attribute special significance to the object dating even to childhood.

Sadism

Von Krafft-Ebing is credited with the term "sadism," derived from the descriptions the Marquis de Sade used in his novels as an "experience of sexual, pleasurable sensations produced by acts of cruelty." (13) Eulenberg described psychological pain in the form of humiliation as linked to sexual arousal. (29) Hirshfeld differentiated major sadism (lust murder, necrophilia, stabbing) from minor sadism (bondage, cutting hair, mild flagellation). (30) If a person with a sadistic interest has a consenting partner, minor sadism could be considered a variant of the norm.

The DSM-5 describes sadism as the presence of recurrent and intense sexual arousal from the psychological or physical suffering (including humiliation) of another person as manifested by fantasies, urges, or behaviours. (17) Some sadists report sadistic or sexually sadistic fantasies extending even before puberty, with sadistic acts often occurring by early adulthood. If these interests escalate to being practised on a nonconsenting partner, there is a high risk of repeated acts until the person is apprehended. In these individuals, the severity of sadistic acts might increase over time. Sadistic offenders are more likely than non-sadistic offenders to have planned their offences; kidnapped their victims; used violence, torture, and humiliation; inserted objects into the victim's vagina; strangled their victims; and engaged in post-mortem intercourse. (24)

The term "rape" is not synonymous with sexual sadism. Rape has been described as a behaviour that represents an expression of aggression rather than a paraphilia. (31) It is a term used in legal proceedings in some jurisdictions or in the media but is not a clinical term. Most individuals committing sexual assault do not have a sexual sadistic or other paraphilic disorder. Motivating factors might instead include antisociality, narcissism (power and control), substance use, opportunity, and attitudes and beliefs about sex and gender relations, among others. People who engage in sexual assault (rapists) as a group tend to resemble other inmates in the criminal justice system in that they tend to have low socioeconomic status, a poor work history, low social competence, a history of caregiver inconsistency, early institutional involvement or living, a history of physical and (or) sexual abuse, and evidence of variability in their sexual offending. (1) There might also be other comorbidities, such as anxiety, depression, substance use, and paraphilias.

Sexual murders are rare, and serial sexual murder is even rarer. Broadly, there are two types of sexual murderers: those who kill for sexual gratification and those who kill during or after a sexual assault for nonsexual reasons. Both can be associated with moderate or even high levels of psychopathy. The former is associated with sexual sadism and other paraphilias and may include necrophilic acts as a form of ultimate control over the victim. The latter is associated with anger (revenge or rage) and (or) self-preservation by getting rid of the witness. The act of killing might not have been planned. (32,33)

Serial sexual murderers, involving at least three murders separated by time, have a higher rate of sexual sadism than nonserial sexual murderers. There is often a rehearsal of fantasies during the period between murders, which may last for months or years. Unlike one-time murderers, who may be governed by circumstances, serial sexual murderers are driven by an inner need (sexual sadism and other paraphilias and revenge/need for power and control), as well as situational factors, which determine where and when it takes place (e.g., the influence of alcohol, stressors, anger in the moment, opportunity, victim response). Serial sexual murderers are often intelligent and have relationships, children, and jobs and are mobile. They may be superficially charming, which might assist in luring victims, who are usually strangers. The harm inflicted can be sexually gratifying even in the absence of an overt sexual act. Their behaviour tends to evolve and escalate over time due both to habituation and the fact that reality rarely lives up to the fantasy script. (24,32).

Paraphilic coercive disorder, defined as a preference for coercive sexual activity or nonconsenting sexual activity, was proposed for inclusion in the DSM-5. (17) It is distinct from sexual sadism in that some people purport sexual arousal to coercive sex that does not involve gratuitous violence, humiliation, or physical harm. There is a lack of consensus on whether this is a distinct category from, or on a continuum with, sadism. (34)

Sadism and masochism are related disorders, commonly referred to as sadomasochism. There is often a spectrum of co-occurrence and severity of expression. The degree of dominance and submission can vary, and motivations, behaviours, consent, and intentions should be considered. (14)

Masochism

The DSM-5 describes masochism as the presence of intense and recurrent sexually arousing fantasies, sexual urges, or behaviours involving being humiliated, beaten, bound, or otherwise made to suffer. (17) This may involve restraint, acts of humiliation, infibulation ("pinning and piercing"), electrical shocks, infantilism, asphyxiophilia (restriction of breathing), sexual assault, or other acts of physical or psychological suffering. A masochist tends to repeat the same masochistic act. There is often a spectrum of interest from mildly severe acts not required for arousal to the most severe acts with highly restricted interest. Dysfunction is more likely at the higher end of the spectrum; such individuals may be at risk for severe and irreversible bodily injury, including castration, penectomy, or even death.

Transvestism

Transvestism is the presence of recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviours. Specifiers include "with fetishism" if the person is sexually aroused by fabrics, materials, or garments and "with autogynephilia" if the person is sexually aroused by thoughts or images of themselves as female. It is important to differentiate this from gender dysphoria, which usually has no sexual arousal to other-gender themes.

Pedophilia

Pedophilia is a persistent sexual interest in children (generally prepubescent children between the ages of 8 and 12 years, with undeveloped secondary sexual characteristics). Pedophilic disorder is a DSM-5 diagnosis involving recurrent, intense sexually arousing fantasies, urges, or behaviours involving sexual activity with a prepubescent child or children over a period of at least six months. (17) Individuals with pedophilia are at least 16 years of age and at least five years older than the child. The circumstance wherein an individual in late adolescence is involved in an ongoing sexual relationship with a 12- or 13-year-old is not included in the definition of pedophilic disorder. There are exclusive (attracted only to children) and nonexclusive types of pedophilia (with sexual interests in both children and adults). They may be attracted to girls, boys, or both. There are incest and non-incest pedophilic offenders (see below).

The term "hebephilia" refers to people with a paraphilic arousal to children developing secondary sexual characteristics (peripubescent). It is unclear whether those who are sexually interested in infants or pubescent children have variants of pedophilia or distinct chronophilias of their own. Infantophilia or nepiophilia describe a sexual interest in children under five years of age.

The DSM-5 defines an individual with a pedophilic sexual orientation but not pedophilic disorder as follows:

> . . . if they report an absence of feelings of guilt, shame or anxiety about these impulses and are not functionally limited by their paraphilic impulses (according to self-report, objective assessment, or both), and their self-reported and legally recorded histories indicate that they have never acted on their impulses (17, p 698).

The literature refers to sexual offenders who offend against children (under age 16 years) in two subgroups: 1) nonfamilial child molesters and 2) incest offenders (victims under age 16 years). Additionally, "child molesters" can further be separated into categories of paraphilic and non-paraphilic, depending on the motivation for offending. If a person has a history of offending against adults and children, they may be called a "mixed offender." These sub-groups differ in criminogenic needs that relate to offending. (35)

Roots of sexual offending against children are multifactorial and can be driven by one or more of the following factors: pedophilia, hypersexuality, opportunity, maladaptive personality traits, or disinhibition by intoxication. Further, an individual with pedophilia might never offend against a child, and many who sexually offend against children do not have pedophilia but are opportunistic. It is estimated that 40% to 50% of sex offenders against children have a pedophilic disorder, (36) with a higher percentage in extrafamilial offenders and with male or multiple victims. The rates of sexual offending and the mean number of victims for any given person are often underestimated due to underreporting, lack of charges or convictions, or other variables. (3,6)

Incest offenders only offend against victims who are members of their family, including children by marriage. Incest offending is more likely to take place when the victim acts as a surrogate partner for the individual and in those who evidence antisocial traits, substance abuse, and poor personal circumstances. Incest offenders might also have pedophilia, although most exhibit normative adult sexual preferences. (35)

Other Specified Paraphilic Disorder

The DSM-5 has a category for paraphilias that are not otherwise detailed and identify erotic foci. Some of the most common are as follows:

Paraphilia	Erotic focus
Zoophilia	Animals
Formicophilia	Small creatures
Klismaphilia	Enemas
Mysophilia	Filth
Urophilia	Urine
Coprophilia	Feces
Vampirism	Blood
Vomerophilia	Vomit
Necrophilia	Corpses
Symphorophilia	Stage-managed disaster
Abasiophilia	Lamed or crippled partner
Acrotomophilia	Amputation in partner
Apotemnophilia	Own amputation
Asphyxiophilia	Self-strangulation
Autoassassinophilia	Staging one's own murder
Autonephioplia	Diapers
Erotophonophilia	Lust murder
Gerontophilia	Older persons
Hypephilia	Fabrics
Kleptophilia	Stealing
Narratophilia	Talking dirty
Pictophilia	Pictures
Somnophilia	Sleeper
Stigmatophilia	Tattoo, piercing
Troilism	Couples

Other Considerations

Female Sexual Offenders

Much of the literature focuses on paraphilias in males. The rates of paraphilic disorders are much higher in males, but they can develop in females. As with their male counterparts, nonparaphilic factors are often equally or more relevant in offending. In recent years, more research and clinical practice has been directed towards the recognition, description, and management of female sexual offenders. (37) Many of the theoretical frameworks and assessment and treatment protocols have not been validated or studied in the long term with female sexual offenders. There is little empirical evidence looking at the link between sexual preferences and interests in females and sexual offending behaviour.

There has been research into the typical characteristics of female sexual offenders focusing on the development of typologies to understand offending pathways and guide intervention strategies. Matthews and colleagues developed one of the first typologies, describing motivational factors in sexual offending in a group of 16 females, using qualitative and quantitative data. (38) They described three main typologies: "predisposed," "teacher/lover," and "male-coerced." The predisposed female offender has typically experienced high levels of sexual abuse in her own background and is characterized by anger, low self-esteem, and emotional instability. She may also experience paraphilic sexual urges and offence-supportive cognitions. The teacher/lover typology involves the idealization of a younger male by an older female who has a history of abuse and relational dysfunction with age-appropriate men.

The understanding of female sexual offenders who act with a male co-accused has evolved to encompass a heterogenous group who harbour different origins to their offending behaviour. Some co-offending females are involved in abusive relationships with the male offender, where they may have been coerced or threatened; some have played a more passive or permissive role; and others have been more actively or equally involved in the offending behaviour. (39) The male-coerced female sexual offender is characterized by lack of assertiveness, feelings of powerlessness, holding stereotypical views of gender roles, low self-esteem, and expectations of rejection. One of the largest empirically driven studies on female sexual offending was limited by the lack of information related to situational factors, which is important, given the significant percentage of females who act with male co-offenders. (40) Some females may be sexually aroused by their male co-accused's arousal during involvement in the offence. (37)

Therapy for females who have been involved in sexual offending behaviours involves modules focused on criminogenic needs, such as self-management, sexuality, social skills, cognitive distortions, trauma resolution, and paraphilic thoughts and fantasies. Sex offender therapy should be gender-specific and trauma-informed. Little is known about the effectiveness of treatment programs in terms of reducing recidivism, partly due to a lack of research, but also because of the low rates of recidivism in this group of offenders. A 2005 review of the literature showed that after an average follow up of five years, weighted averages showed a sexual recidivism rate of 1% and a violent recidivism rate of just over 6%. (41) More recent research has noted that females who recidivated sexually were more likely to have had prior convictions, increased age, and an index offence that involved promoting sex trade work and more victims. (42)

Child Pornography/Internet Offenders

The term "Internet offender" refers to people who engage in the production, possession, or distribution of child pornography or another behaviour that involves the solicitation or grooming of children. (43) There has been some debate about whether Internet offenders are similar to hands-on offenders. A central issue is whether the individual has only ever engaged in Internet offending or has also engaged in hands-on offending, which may depend on their self-report. Seto and colleagues conducted a meta-analysis of studies examining a history of contact offending in Internet offenders; approximately one in eight had an official record of contact offending, but self-report data suggested one in two admitted to a contact offence. (44) Multiple typologies have been suggested to help understand Internet offenders, including grooming and luring. (45–47)

Non-Paraphilic Problematic Sexual Behaviour

Non-paraphilic motivations may also be identified for engagement in problematic sexual behaviour, such as major mental illness (for example, disinhibition or disorganization related to schizophrenia and intrusive sexual thoughts related to obsessive–compulsive disorder), association with broader personality dysfunction, impulsivity, cognitive factors, and substance use. (48) The forensic assessor attempts to parse out the relative contribution of each of these factors to the sexual behaviour; some individuals may evidence a paraphilia comorbid with another disorder that might be contributing to or unmasking the behaviour. The effects of these conditions (such as distress intolerance, disinhibition, neurocognitive disorder, grandiosity, heightened sex drive, and delusional beliefs) may be driving factors related to problematic sexual behaviour and inform assessment and management planning.

Hypersexuality (Also Referred to as Sexual Addiction)

Individuals may seek assistance for increased frequency or intensity of sexual urges and behaviours, even though the behaviours themselves may not be inappropriate or atypical. Increasingly, these behaviours have colloquially been referred to as "sexual addiction" or, in more clinical terms, "hypersexuality." Hypersexuality was proposed for inclusion in the DSM-5 but ultimately not accepted, despite the generation of criteria and field testing. (49,50) However, the diagnosis of compulsive sexual behaviour disorder was adopted in the International Classification of Diseases (ICD-11) and described, among other criteria, as being "characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour." (51) Regardless, the clinical entity can have significant implications in criminal and civil law. (52)

Multiple theoretical models have been developed to explain hypersexual behaviours, including addiction, (53) compulsivity, and impulsivity models. (54) It is important to ascertain whether the individual evidences a paraphilia, as there is often heterogeneity in the presentation of those with sexual addiction. Cantor and colleagues suggested a clinically useful, albeit perhaps not universally adopted, typology for hypersexual behaviour. (55) This typology was based on referrals to a large urban sexual behaviours clinic and comprised paraphilic hypersexuality (high frequency of sexual behaviours sufficient to lead to distress and often multiple subclinical paraphilic interests); avoidant masturbation (excessive amounts of time viewing pornography and masturbating to the exclusion of other activities); chronic adultery (increased frequency of affairs); sexual guilt (distress over sexual behaviours, despite not engaging in overt behavioural extremes); the "designated patient" (patient's behaviour has been defined as extreme by their partner); and better accounted for as a symptom of another condition.

It is recommended that clinicians employ a multifaceted or multimodal approach to treatment that is tailored to individual needs. For some, that means no treatment at all but, rather, sexual education and lifestyle integration of their sexual behaviours. (55) For others, treatment of hypersexuality might include medication (sex drive–reducing, anti-anxiety, or antidepressant medication), cognitive-behavioural therapy, couples' counselling, or sex therapy. (53–57)

Age and Sexual Offending

Studies of human sexuality and aging indicate a general decline in male sexual behaviour throughout the lifespan, evidenced by decreases in erectile response and latency. (58) Sexual libido is also known to decrease with age in sex offenders. (59) Although the literature describes an overall decrease in risk of sexual offending with advanced age, some sex offenders continue to offend well into old age. This highlights the importance of a comprehensive assessment that addresses individual risk factors. (60)

Studies have shown that sexual recidivism decreases with age at release from custody. Hanson examined the relation of age to sexual recidivism using data from 10 follow-up studies of adult male sexual offenders (a combined sample of 4,673). (61) Rapists were younger than child molesters, and the recidivism risk of rapists steadily decreased with age. In contrast, extrafamilial child molesters showed little reduction in recidivism risk until after age 50 years. The recidivism rate of intrafamilial child molesters was low. Developmental changes in sexual drive, self-control, and opportunities to offend might impact the reduction in offending over time. According to a sample from Hanson, the estimated recidivism rate at age 70 years was zero. (61) This may be confounded by several issues, including decreased community access for sex offenders deemed high risk. Barbaree and colleagues reviewed the recidivism rates of 468 adult sex offenders at Warkworth Institution between 1989 and 2001 (average age at release was 40 years). (62) The sexual recidivism rates decreased in a linear fashion with age at release, when time at risk was controlled.

Sexual offending against children could decrease over time based on decreased sex drive with age (or with sex drive–reducing medication), decreased opportunity, alternative interests (including meaningful relationships and activities), a desire and commitment not to re-offend, declining physical health, and other factors. Offending may be less likely to decrease if someone also has associated factors, such as a paraphilic sexual interest or sexual sadism. (63)

Treatment of Paraphilias

The treatment and management of paraphilic disorders and sexual offending remains an area under ongoing investigation, with variable quality and efficacy in existing studies. (64) Treatment modalities used in paraphilias include pharmacotherapy and psychotherapeutic interventions.

The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the biological treatment of paraphilias provide recommendations for those who diagnose and treat people with paraphilias in clinical practice. (6) Treatment aims to:

- control paraphilic fantasies and behaviours to decrease the risk of recidivism;
- control sexual urges;
- decrease the individual's level of distress; and
- enhance non-paraphilic sexual interests and behaviours.

Surgical castration is rarely used. Most of the literature in this area is from large samples in the 1920–1960s in Europe, although there were poor research designs. There were also significant ethical concerns; for example, some of these studies involved people with intellectual disabilities who were castrated without their consent. There was a substantial reduction in sexual recidivism, although some males retained some sexual interest and functioning. (65,66)

Pharmacological sex-drive reduction may be used in people with paraphilic disorders, (67) though there is a high discontinuation rate. (68) The choice of medication will depend on comorbidities, medical history, intensity of the paraphilic fantasies, risk of sexual violence, the individual's preference, and informed consent. (6) Reduced sexual drive might make some people more responsive to psychotherapy. (69) Notably, sexual preference will not change with pharmacological treatment, but arousal and sexual drive are expected to attenuate or abate. (6) Poor treatment compliance and refusal are significant concerns with sex drive–reducing medications. (68) This is related to side effects (including lowered sexual drive) and the common problem of waning treatment motivation. Also, covert use of exogenous androgens can circumvent the use of sex drive–reducing medication, thus free testosterone levels in the blood are often monitored.

Pharmacological treatments fall into three categories: selective serotonin reuptake inhibitors (SSRIs), antiandrogen medications (medroxyprogesterone and cyproterone acetate), and gonadotropin-releasing hormone (GNRH) agonist medications (leuprolide acetate and triptorelin). A full review of sex drive–reducing medications is beyond the scope of these guidelines. The efficacy of these medications is usually measured by self-report or hormonal levels. Research into the long-term effects of medication treatment on sexual recidivism is limited.

Psychological treatments aim to address sexual offence–specific factors, including paraphilic interests, nonsexual criminogenic factors such as substance use and impulsivity, relapse prevention, and a focus on identified risk variables. The most common framework for psychological treatment is cognitive-behavioural therapy. This involves challenging offence-supportive cognitions, addressing self-regulation and problem-solving skills, managing affective states, and reducing sexual arousal (70,71). Other common forms of psychological treatment include acceptance and commitment therapy, behavioural therapy, relapse prevention, systemic treatments, and family therapy. The Good Lives Model is an intervention framework that emphasizes the importance of a holistic approach and focuses on meeting the needs of sexual offenders ("primary goods") in more adaptive and prosocial ways. (72) The Good Lives Model treatment plans focus on individuals' preferences, competencies, and strengths. The components of effective treatments include the development of a historical biography. This forms the basis for developing the pattern of offending (crime cycle), which in turn identifies and targets risk factors in need of modification. Several other factors might impact treatment outcomes, including program integrity, adherence to best practices, staff selection, and individual factors, including treatment readiness, adherence, concept acquisition, and past treatment response. (70,71)

SEXUAL BEHAVIOUR ASSESSMENTS AND SEXUAL OFFENDING RISK ASSESSMENTS

This guideline provides a structure for sexual behaviour assessments. The reader may wish to seek additional references. (73,74)

Types of Sexual Behaviour Assessments

Forensic assessors may be asked to address a several issues related to an evaluee's sexual behaviour or interests that can broadly be categorized into three areas. The first is a diagnostic evaluation to determine if a paraphilic disorder is present. As with any psychiatric evaluation, the assessor will also consider any co-occurring mental conditions that may be impacting the individual and their potential contribution to the offending behaviour. The second is a risk assessment of sexual offending. As outlined below, risk assessments may address short-, medium-, and long-term risk and can use a combination of actuarial and structured professional judgement tools. The choice of tools depends on the type of sexual offending (i.e., contact vs. non-contact vs. child pornography–only offending). As with any forensic risk assessment, determining the risk of sexual offending addresses not only the probability of offending in the future but also imminence, nature, frequency, re-offence scenario, and potential victim pool. The third concerns treatment and management recommendations for those who have engaged in sexual offending or problematic sexual behaviour. In addressing this, the assessor must first formulate the motivations or conditions driving the sexual behaviour, then determine the treatability or manageability of those factors or conditions, and lastly predict the evaluee's success in responding to such treatment or management recommendations given the individual's case-specific variables.

Sexological assessments are conducted at any stage of the court proceedings if a person has been charged with a sexual offence. Court-ordered assessments are typically requested after an agreed statement of facts has been settled or after a finding of guilt. Defence counsel, however, can request an assessment before a finding of guilt, and which might include treatment recommendations and sometimes even participation in sex offender treatment prior to completing the proceedings.

The Assessment

Settings

The forensic assessor can conduct a sexological assessment in any setting, with the usual parameters of safety and professionalism, as outlined in the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles. Phallometric testing is ideally done within a laboratory with published data on the specificity and sensitivity of its testing outcomes.

Assessment Style

Discussing sexual preferences and practices might be uncomfortable, perhaps more so in the context of those who have engaged in sexual offending; this might impact the offender's willingness to disclose information. To mitigate this, forensic assessors strive to ensure the tone and environment of the evaluation are respectful and professional. To create this atmosphere, the assessor needs to be comfortable addressing uncomfortable topics and sexological questions in a straightforward and non-judgemental way. The assessor can help the evaluee be more comfortable by starting the interview with more neutral areas, such as development history, and providing introductory statements on the next area of inquiry. In certain situations, an evaluee may admit to their sexual preferences more openly when responding to a written questionnaire.

Sources of Information

Assessors use all information sources available during forensic evaluations (see the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles and the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Violence Risk Assessment). Additional material might include reports from past sexual behaviour treatments and prior phallometric test results. Collateral interviews with people who know about or have experience with the evaluee's sexual behaviour can also be helpful (with the assessor weighing this information according to the objectivity, consistency, and quality of the source).

Depending on the type, a sexual violence risk assessment involves gathering information from a variety of sources to enhance the reliability of the data and ensure they reflect historical, longitudinal variables important to assessing risk. This might include documents listed in Table 7 of the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Violence Risk Assessment, such as criminal records, offence-related materials, jail records, mental health and past risk assessments, and records pertaining to the evaluee's upbringing, education, and work history. The assessor seeks collateral information from family, friends, work associates, and past or present partners to further understand the personality, sexual history, relationship history, and other factors relevant to the evaluee's offence cycle or risk of recidivism. Standardized testing can provide objective measures of their personality, cognitive functioning, coping style, psychopathology, and reliability of self-report. It is at the assessor's discretion whether to include additional sources of information, such as other medical consultations, electrophysiological imaging, blood work investigations, and urine drug screening. Finally, penile plethysmography is often considered in sexual behaviours and violence risk assessments, as discussed below.

Reviewing Pornographic Material

Assessors may be asked, or should at times seek, to review photographs, videos, or descriptions of pornographic materials possessed or produced by the evaluee. Such information can help determine if a sexological diagnosis is present, though it may come at a cost to the assessor if the material viewed is psychologically disturbing. The literature has described vicarious trauma, a form of traumatic stress disorder that forensic practitioners assessing and treating sexual offenders can be at risk of acquiring. (75) Instead of viewing the material firsthand, the assessor may consider requesting a summary of the material and, if possible, that it includes areas that will be diagnostically helpful, such as quantity of paraphilic versus non-paraphilic pornographic material, gender and age range of those portrayed, and nature of the sexual interactions. Another option is to request that the photographs or video material be culled into a representative sample. The assessor can then decide whether to accept cases in which the material may be, or has been, traumatic.

Interview Content—General

As in any forensic evaluation, the length and depth of the interview depends on factors such as case complexity, evaluee communication style, and nature of the questions posed. Each assessment begins with a preliminary caution on the limits of confidentiality inherent to the interaction. Areas specific to a sexual behaviours assessment that might be highlighted during this caution include mandatory reporting obligations that relate to vulnerable parties, potential victims, and those who will have access to the report, which may contain subject matter deemed sensitive by the evaluee.

The material covered in a sexual violence risk assessment largely mirrors that of a violence risk assessment (see the Canadian Guidelines for Forensic Psychiatry Assessment

and Report Writing: Violence Risk Assessment) and addresses empirically derived criminogenic factors (such as personality structure, criminal history, substance use, impulsivity, comorbid conditions, etc.). Additional areas of focus or elaboration pertain to the evaluee's relationship and sexological history and an account of all sexual offences or behaviours of concern. An evaluee's perception of their own history of sexual abuse, if present, might also be instructive. These lines of questioning are not only essential for diagnostic purposes but also to capture risk factors specific to sexual offending (e.g., the presence of a paraphilic disorder), as well as treatment readiness or response (e.g., offence-supportive cognitions that facilitate sexual-offending behaviours).

When reviewing an evaluee's relationship history, the assessor may seek greater depth of information pertaining to the nature and quality of their intimate relationships. They might ask questions about the evaluee's experience of love and fidelity, the nature and quality of their sexual interactions, their exposure to domestic violence, as well as what attracted the evaluee to their partners. The assessor might also canvass the psychosocial circumstances of the evaluee's partner that may relate to their understanding of the offence scenario (e.g., an evaluee with pedophilia choosing women with children as partners).

In reviewing an evaluee's legal history or offence-related behaviours, the assessor considers two categories: sexual offending and nonsexual offending. For both categories, the assessor reviews the offence scenario, which might include the nature of each charge and conviction, victim injury, the evaluee's psychosocial circumstances at the material time, role of substance use, length and type of sentence, and responses to treatment and supervision. For sexual offending history, the assessor pays particular attention to the victim profile for each offence (e.g., age, sex, nature of sexual interaction, duration of offending), as well as offence-enhancing factors (e.g., substance intoxication, victim choice and accessibility, and degree of risk an evaluee took to engage in the offending behaviour). Assessing the degree of psychological or emotional coercion between the evaluee and the victim and the degree of physical force used in the commission of the offence will help the assessor develop a re-offence scenario.

Sexological History

The sexological history may be the most unique area of inquiry distinguishing sexual violence risk assessments from other forensic evaluations. Table 1 shows a breakdown of the sexological history that covers the main domains of inquiry. These areas contribute to the diagnostic or motivational understanding of the evaluee, in addition to aiding the assessor in determining an evaluee's insight, treatment response, and risk profile. An assessment of paraphilias may also involve self-report questionnaires.

Interview Content—Sexual Offending Against Children

A pedophilic disorder may be diagnosed based on the evaluee's self-report of sexual preference, evidence of a paraphilic sexual preference on phallometric testing in a laboratory with published or available sensitivity and specificity data, criminal offending involving sexual behaviour with a child, or engagement in a pattern of behaviour that cannot reasonably be explained by any other psychiatric diagnosis or formulation.

Table 2 delineates variables to consider when evaluating an individual who has offended sexually against a child; these include factors pertaining to diagnosis, acute and long-term risk, and re-offence scenarios. The assessor reviews potential risk-enhancing scenarios and potential victim access in their current life circumstances (e.g., involvement in activities associated with paraphilic interests, such as being a scout leader or coach, online activities with minors, involvement with romantic partners who have young children, etc.) that may necessitate mandatory reporting obligations. To understand a potential re-offence scenario, the evaluator assesses for grooming and luring behaviours designed to build trust and desensitize victims to increasing levels of sexual intrusion. Offence-supportive cognitions related to sexual offending against children are often canvassed as part of treatment readiness and progress assessments. Table 3 contains examples of offence-supportive cognitions and questions asked to elicit these beliefs. The forensic assessor canvases whether the evaluee has associated with people who have sexually offended against children (online or in person), who have offered offence-supporting rationalizations, or with whom paraphilic pornographic material was exchanged.

To be used in conjunction with or absent phallometric testing, Seto and colleagues developed the revised Screening Scale for Pedophilic Interests (SSPI-2), an instrument that examines pedophilic preference based on sexual offending details. (76) Items include any boy victim under the age of 15, multiple child victims under age 15, any child victim under age 12, any extrafamilial victims under age 15, and possession of child pornography. Higher scores are more suggestive of pedophilic interest.

Interview Content—Coercive Sexual Behaviour

The evaluator pursues additional areas of inquiry when assessing someone with a potential coercive-spectrum disorder that involves using force to gain compliance or with more overtly sadistic preferences. Recalling that those with coercive sexual behaviours often have multiple paraphilias that require screening and assessment (such as sadism, voyeurism, exhibitionism, and telephone scatologia), the assessor asks about the evaluee's attitude towards the victim's gender, desire to exert power and dominance over others, psychological and nonsexual abuse of victims, and planning and organization of the offence(s). (77) Table 4 outlines areas of inquiry for this specific population of offenders.

Table 1. Example of Elements of a Sexual Behaviour History

Sexual Behaviour Leading to Assessment

- Behaviour of concern
  - as perceived by the evaluee
  - as perceived by others (including charges as applicable)
- Steps in the offence cycle (from conception to execution)
- Degree of risk taken to achieve sexual satisfaction
- Victim characteristics
  - Age and gender
  - Relationship to victim
  - View of victim impact and response
- Influence of disinhibiting factors
- Offence-supportive cognitions
  - Level of denial or minimization
  - Understanding of victim's experience/perspective
  - Attribution of responsibility / victim blaming / rationalizations
- Prior charges and convictions (if applicable)
  - Legal history including sex offences
  - Response to sanctions, supervision orders, recommendations (e.g., probation)
- Any unreported sexual offending behaviours

Sexual Development and Knowledge

- Onset of puberty and development of secondary sexual characteristics
- Gender identity
- Sexual knowledge: anatomy, function, behaviours
- First exposure to sexual information (school, peers, family, formal sexual education, other)
- Familial and cultural attitudes regarding sex
- Sexual abuse history or early sexualization
- Sexual functioning (e.g., difficulties with erection/arousal, ejaculation, orgasm)
- Genital abnormalities and body image
- Primary sexual interest:
  - Gender
  - Body type
  - Age range
  - Perceived strength of arousal to different ages or genders and sexual interests and activities (e.g., scale from 1 to 10)
- Engagement in behaviours that do not align with reported primary sexual interest
- First consensual sexual encounter: activity, age, gender of partner

Indicia and Perception of Sexual Drive

- Masturbation
  - Onset
  - Frequency and duration
  - Location
  - Fantasies
  - Impact on functioning

continued

Table 1. Continued

- Number of sexual partners
  - Relationships
  - Casual encounters
  - Frequency and type of sexual behaviour
- Pornography
  - Age and circumstances of first exposure
  - Frequency and duration of use over time
  - Types of sites (including paying for access)
  - Preferred sexual behaviours and targets
  - Child pornography
  - Creating or distributing pornography
- Sex trade
  - Being paid for sex
  - Paying for sex: sex trade workers, phone sex, massage parlours, bathhouse
  - Strip clubs
- Perception of sexual drive
  - How often do you think about sex?
  - Is your sex drive higher than / equal to / lower than other people your age?
  - Has anyone commented on your sex drive?
  - Have you missed social or vocational obligations due to time spent on sexual activities?
  - Do you use sex to cope with negative feelings such as anger, boredom, anxiety, or frustration?
  - What is the impact of drugs and alcohol on your function and desire?
  - What is your capacity to control your sexual impulses?

Sexual Interests and Behaviours

- Non-paraphilic sexual fantasies, interests, or behaviours (level of interest and frequency of behaviours)
  - Vaginal sex
  - Anal sex
  - Oral sex
  - Other interests
  - Use of paraphernalia/objects including sex toys and aids / specific clothing / audio/video recordings
- Paraphilic sexual fantasies, interests, or behaviours (level of interest and frequency of behaviours)
  - Pedophilia
    - Focused behaviours to facilitate sexual desire:
      - Engagement with scouts, coaching, teaching
      - Collecting child-focused materials
      - Involvement in relationships to increase opportunity for access to victims
  - Exhibitionism
  - Voyeurism
  - Frotteurism
  - Sadism
    - Pleasure from humiliating or causing pain: strangling, biting, hitting, etc.
    - Asphyxiation and autoasphyxiation
    - Use of threats, force, abduction, bribes, persuasion, drugs/alcohol
    - Associated nonsexual violence
    - Behaviour if could get away with it

continued

Table 1. Continued

- Masochism
- Fetishism
- Transvestic fetishism
- Urophilic/coprophilic behaviours
- Sexual contact with animals
- Telephone/Internet scatalogia
- Other paraphilias

- Stalking behaviour (online or in person)
- Rape interest or preference

Influence of Disinhibiting Factors

- Substance use
- Personality disorder/dysfunctional personality traits (e.g., impulsivity, lack of empathy and remorse, entitlement and grandiosity, poor behavioural controls)
- Symptoms of a major mental disorder (e.g., mania, psychosis, anxiety)
- Cognitive disorders (e.g., dementia, intellectual disability)
- Organic disorders (e.g., seizures, head injury)
- Impulse control disorders

Opportunity

- Access to victims
- Proximity to victim-focused environments and activities
- Engagement in high-risk activities
- Level of supervision

Sexual Behaviour Treatment (individual and group therapy, medication)

- History of treatment and response (subjective and objective)
- Willingness to initiate and commit to treatment
- Desire to change
- Barriers to change

Table 2. Assessment Variables Related to Sexual Offending Against Children

- Self-report of offending history
- Number of victims
- Victim characteristics
  - Gender, age, relationship
- How victim access was obtained, including grooming behaviours and vulnerability of the victim(s) and their caregivers
- Degree of risk assumed in committing the offence(s)
- Subsequent masturbation to thoughts of offending
- Use of child pornography
- Child-focused activities
- Access to children at the time of assessment
- Association with people with paraphilic interests
- Offence-supportive cognitions
- Penile plethysmography results

Table 3. Examples of Offence-Supportive Cognitions Related to Sexual Offending

Offence-Supportive Cognition	Questions to Elicit Offence-Supportive Cognitions
The victim wanted or initiated the sexual interaction.	Was the victim coming on to you? Were they attracted to you, or did they want sex?
The victim enjoyed the sexual interaction.	Describe the victim's facial expression and comments during the offence. Did the victim enjoy or were they aroused by the interaction?
The victim was capable of consenting to the sexual interaction.	Are some children capable of consenting to sexual activity? Except for the victim's age, was your victim capable of consenting to the sexual interaction?
The victim benefitted from the sexual interaction.	Did your attention and sexual interactions help or benefit the victim? Do children benefit from exposure to sexual interactions with an adult?

Sexual Preference Testing

Penile plethysmography (phallometric testing) measures changes in blood flow to the penis when presented with standardized visual and (or) audio stimuli. The most common tests are used to identify arousal in males to gender and age stimuli and coercive sexual stimuli. They often include visual and auditory depictions of prepubescent, pubescent, and adult males and females and may include audio depictions of sexual behaviours with scenarios involving differing degrees of consent. Tables on the sensitivity and specificity of the tests have been published and range from 42% to 100% sensitivity and 80% to 100% specificity. (78) The forensic assessor should be familiar with the nature and purpose of the test being used, sensitivity and specificity of the lab and stimulus set being used, and relevant literature around phallometric testing, including limitations. Phallometric test results are not diagnostic and should not be the sole indicator of a paraphilia or risk marker. A paraphilic diagnosis is formulated in the context of the broader assessment, including details of any offending behaviour.

Vaginal plethysmography has been developed to assist in assessing sexual arousal patterns in females, (79) based on the observation that vaginal blood flow increases during sexual arousal. The parameters of testing are not well validated, and it is not widely available or used.

Another measure used to identify sexual preference is visual reaction time (VRT). VRT is based on the premise that people look at arousing stimuli for a longer time than neutral or not arousing stimuli. (80) Other tests used in clinics, sometimes with controversy, are polygraphs, electroencephalography, fMRI, visual eye tracking, and pupillary dilation. (14)

Table 4. Assessment Variables with Coercive-Spectrum Disorder Offences

- Sexual fantasies or use of pornography depicting pain, suffering, or humiliation of others
- Self-report of offending history and non-paraphilic reasons for offending
- Offence planning—duration, fantasies, preparation of a rape kit, victim surveillance
- Type of sexual violence (e.g., bondage, anal rape, strangulation)
- Degree of force used in the commission of offence—just enough to gain compliance or excessive use of force causing pain and suffering
- Infliction of nonsexual violence during commission of offence
- Victim response and arousal to victim fear, pain, or humiliation
- Subsequent masturbation to thoughts of offending
- Attitudes toward the victim's gender and desire to exert power or dominance
- Collection of souvenirs from the victims
- Co-occurring paraphilias
- Co-occurring personality pathology, specifically psychopathy, and narcissistic personality disorder
- Penile plethysmography results

Table 5. Assessment Variables Related to Exhibitionism

- Self-report of exhibitionism: age of onset, frequency, pattern
- Fantasies and motivation for behaviour
- Fantasy for how the victim would react to the behaviour:
  - Admiration
  - Arousal and expression of sexual reciprocity
  - Shock, fear, anger, disgust, or laughter
  - No reaction
- Number of victims
- Victim characteristics (age, gender, location, etc.)
- Associated behaviours
  - Exposure of genitals (+/- erection), buttocks
  - Public masturbation
  - Post-exposure behaviour
- Subsequent masturbation to thoughts of offending
- Degree of risk assumed in committing the offence(s)
- Association with other paraphilic behaviours (e.g., voyeurism, coercive sexual behaviour, pedophilia)
- Engagement in non-paraphilic sexual behaviour
- Relationship affiliation and preference
- Offence-supportive cognitions and view of behaviour

Table 6. Assessment Variables Related to Voyeurism

- Self-report of voyeurism and changes over time
- Number of victims
- Victim characteristics
- Setting (outside, inside the victim's residence)
- Degree of risk assumed in committing the offence(s)
- Associated rape fantasies or preparation of a rape kit
- Association with other paraphilic behaviours (e.g., voyeurism, coercive sexual behaviour, pedophilia)
- Engagement in non-paraphilic sexual behaviour
- Subsequent masturbation to thoughts of offending
- Relationship affiliation and preference
- Offence-supportive cognitions and view of behaviour (e.g., the victim was a knowing participant)

Other Testing

If indicated, the assessor might do additional testing, such as psychometric measures for cognitive functioning, malingering/symptom exaggeration or minimization, biological tests, or urine drug screens. Sexual behaviour rating scales and questionnaires can also be used (e.g., the Derogatis Sexual Functioning Inventory [81]; Buss-Durkee Hostility Inventory [BDHI] [82]; Cognitive Distortions Scale [83]; Bradford Sexual History Inventory [84]; and Fantasy Checklist [85]).

Sexual Offending Risk Assessment (as Applicable)

The following is an overview of sexual violence risk assessment tools and not intended to replace requisite training in the field. Readers are encouraged to consult the literature for further details and more in-depth reviews.

Risk factors are variables that increase the likelihood of future offending. (86) Hanson and Bussiere described static risk variables (that is, they are historical or inherent to the offender) and dynamic variables (those that can change over time), both of which are important to sexual violence risk assessment as they pertain to the likelihood of recidivism. (87) Further, they identified stable and acute dynamic factors, the former being variables in which change is slow over a long period of time and the latter being rapidly changing states more proximal to offending. (87) Dynamic risk factors are often important in identifying the timing of an offence, articulating a re-offence scenario, and informing risk management.

Assessing risk of sexual offending involves focusing on static and dynamic factors linked to recidivism among sexual offenders: criminal history, victim-related variables (e.g., stranger, unrelated, male), paraphilias, antisocial orientation, intimacy and relationship difficulties, sexual compulsivity, and problems with self-regulation (hostility, substance abuse, impulsivity). (1,88) Specific paraphilias and antisocial lifestyle are the two strongest predictors of recidivism among sexual offenders. (89,90)

There are both actuarial risk assessment tools and structured professional judgement tools that can be used to identify a composite assessment of sexual recidivism risk. According to a 2007 meta-analysis, empirically validated actuarial instruments were superior in their ability to predict recidivism for sexual offenders. (91) These instruments offer probabilistic estimates of risk for people in the reference sample who scored similarly to the offender. Some of the actuarial instruments are listed in Table 7, and the more commonly used tools are further discussed below.

Hanson and Thornton developed the STATIC-99 as a screening tool to identify risk of sexual re-offending in males who have committed a sexual offence. (97,92) It takes into account several factors known to be related to sexual recidivism, including prior sex offences, male victims, and unrelated victims. It can be used to score historical information (i.e., without an interview being necessary). This instrument takes into consideration some, though not all, factors related to recidivism. The STATIC-99 has been shown to be of moderate predictive accuracy for both sexual recidivism and violent recidivism in males with a history of at least one sexual offence with a victim (i.e., not child porn offences only, unless there is an identifiable victim). The STATIC-99R is derived from the STATIC-99 and includes age at release from custody.

The Sex Offender Risk Appraisal Guide (SORAG) is derived from the Violence Risk Appraisal Guide (VRAG) to help determine the risk of violent recidivism (including sexual offending) among adult male sexual offenders who have committed a sexual offence. (98) The Psychopathy Checklist-Revised (PCL-R) score is one of the items included in this risk instrument. (99) Others include (but are not limited to) prior sexual offences, age and gender of victims, and phallometric testing indicative of a paraphilic interest. The SORAG is recommended for use in people with a history of sexual offending and offers a probabilistic

Table 7. Actuarial Risk Assessment Tools

Risk Assessment Tool	Population	Outcome
STATIC-99R (92) and STATIC-2002R (92)	Adult males who have committed a sexual offence	Sexual and violent recidivism
Violence Risk Appraisal Guide (VRAG), (93) VRAG-Revised (VRAG-R), (93) and Sex Offender Risk Appraisal Guide (SORAG) (93)	Adult males who have committed a violent offence	Violent recidivism (including sexual recidivism)
Rapid Risk Assessment of Sex Offender Risk (RRASOR) (94)	Adult males who have committed a sexual offence	Sexual recidivism
Minnesota Sex Offender Screening Tool-Revised (MnSOST-R) (95)	Adult males who have committed a sexual offence (not for incest offenders)	Sexual recidivism
Risk Matrix 2000 (96)	Adult males who have committed a sexual offence	Sexual recidivism

estimate based on the research samples. The definition of violent recidivism includes being arrested for acts such as homicide, attempted homicide, forcible confinement, assault, and sex crimes involving physical contact. It does not include being arrested for uttering threats, property-related crimes, possession of a weapon, or sexual crimes not involving physical contact. The SORAG score does not predict context, violence severity, when an individual may offend, or the impact of age (other than age at offence). The authors of these two instruments have recommended the SORAG be used with sex offenders and the VRAG with nonsex offenders. The SORAG is similar to the STATIC-99 in its predictive accuracy. This is similar to the more commonly accepted violence risk assessment tools, partly because they cannot consider all variables over time that result in violence. As well, like any statistically based instrument, in actuarial tools there is a loss of predictive accuracy when moving from the group to individual cases (there can be significant variation within the group, and not all in the group re-offend). The VRAG-R was developed from the VRAG and SORAG to assist in understanding risk for violent recidivism (including sexual offending) among adult male offenders, although there are limited cross-validation studies. (93)

Structured professional judgement tools are used to help identify potential targets for treatment and management recommendations. As such, some assessors might use relevant factors from a combination of instruments as an *aide-mémoire* when devising an individualized risk management plan. Protective factors (e.g., prosocial views, age, cooperation with treatment, etc.) are always considered. Some of the structured professional judgement tools include the STABLE-2007, (100) ACUTE-2007, (101) SVR-20, (102,103) VRS-SO, (104) and CPORT. (105)

The STABLE-2007 is a dynamic risk assessment tool for sexually risky behaviour in males. (100) It assesses risk over months and can track changes in risk status over time. Risk factors on this instrument include negative social influences, intimacy deficits (incapacity for stable relationships, emotional identification with children, hostility toward females, general social rejection, lack of concerns for others), sexual self-regulation deficits (sex drive/preoccupation, sex as coping, anomalous sexual preference), poor problem-solving abilities, poor supervision cooperation, impulsivity, and negative emotionality. Protective factors that may reduce risk include resilience, intelligence, community support and positive social influences, secure attachments, concern for others, prosocial values and behaviours, feasible plans, active problem solving, and cooperation with supervision.

The ACUTE-2007 assesses the rapidly changing risk factors that correlate with sexual recidivism in adult males and can assess risk over days to weeks. (101) The first factor predicts sexual and violent re-offending with four risk factors: victim access, hostility, sexual preoccupation, and rejection of supervision. The second factor predicts general criminal recidivism with the same four risk factors, in addition to emotional collapse, the collapse of social supports, and substance abuse, for a total of seven items.

The Sexual Violence Risk-20 (SVR-20) is a 20-item structured professional judgement tool used to examine the level of risk in criminal and civil forensic contexts in males who have committed, or are alleged to have committed, an act of sexual violence. (103,106) It examines psychological adjustment, history of sexual offences, and future plans. There is moderate to good predictive accuracy of sexual recidivism, although the research is limited.

The Violence Risk Scale-Sexual Offence Version (VRS-SO) is designed to assess risk of sexual offending, identify treatment targets, and measure changes in risk post-treatment. (104,107) It contains seven static and 17 dynamic variables identified based on empirical and theoretical literature related to sexual recidivism. It is used for adult male sexual offenders in criminal and civil forensic contexts.

The Child Pornography Offender Risk Tool (CPORT) is a risk assessment tool specifically designed for males convicted of child pornography offences. (105) It predicts sexual recidivism for this population, although further validation is required. (105,108) The seven items on the CPORT include age at index offence, prior criminal history, prior or index conditional release failure, contact sexual offending, evidence of pedophilic/hebephilic sexual interests, greater boy than girl content in child pornography, and greater boy than girl content in other child depictions. The Correlates of Admission of Sexual Interest in Children (CASIC) scale can be used to assess pedophilic/hebephilic sexual interests, in conjunction with the CPORT. (109)

The risk assessment instruments described above attempt to identify the potential risk of a future sexual offence occurring over a set period. All assessors must consider the limitations of the tools used and the degree to which the evaluee represents a given development sample. The limitations include (but are not limited to)

- moderate predictive accuracy of most tools,
- inability to address all static and dynamic variables relevant to the risk of recidivism, and
- inability to address all aspects of risk, such as frequency, imminence, nature and severity of offending, and victim pool.

Many dynamic risk factors are not addressed in the risk instruments but by understanding the individual's history of offending, current circumstances, personality and sexual variables, and other features. The assessor should identify areas of strength and protective or risk-mitigating factors. An area of ongoing research includes the cross-cultural applicability of risk instruments. There may be relevant cultural factors to consider, including whether the tool has been found to be reliable and valid in the population represented by the evaluee (for example, Indigenous offenders).

Notably, no sexual offending risk assessment tools have been created for or validated in a female population or sample.

Special Considerations

Duty to Report

Not uncommonly, assessors will face a less-than-clear question of whether the evaluee meets the threshold of a duty to report to the appropriate parties. For example, there may be a duty to report when a child pornography user who has no known history of contact offences has unsupervised access to minors. Given the unclear risk associated with this scenario, the assessor must determine if this meets the threshold for reporting to child protection services. Such dilemmas in the field of sexual assessments are common and complex and warrant further discussion and examination. (110) See the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles for further discussion of the issue.

The Elderly

Population studies have shown what appears to be a progressive decrease in violent offending with advancing age. This may be related to biological variables, such as a reduction in testosterone, a decrease in physical prowess, or the development of various medical conditions. Despite the statistical drop, some offenders start or continue sexual offending well into old age. (60) Further, this effect may not be as pronounced in specific types of offending, such as sexual offending involving extrafamilial children, where offenders tend to show a decline in violent offending later in life. (61) Such factors such as sadism and disinhibitors (e.g., dementia, substance intoxication) may reduce the impact of age-related decline in risk. The STATIC-99R accounts for the offender's age at release, with advancing age decreasing the score on that instrument. Notably, there is no direct linear correlation between any one factor and risk. Therefore, although age must be considered a potential mitigating factor in all cases, it cannot be viewed in isolation but in the context of an individual's other known and case-specific risk factors.

Impact of Intellectual Disabilities or Autism on Sexual Offending Risk Assessment

For people with intellectual disabilities, disentangling paraphilic from non-paraphilic motivations can be challenging, given that sexual behaviours in this population can sometimes be expressed in a diffuse, indiscriminate, and disinhibited fashion. Some research indicates that inappropriate sexual behaviour is expressed in 45% to 52% of adults with prenatal alcohol exposure. (111,112)

For people with autism, difficulties with social skills, or relationship deficits and those who misunderstand the seriousness of their behaviours, their expressions of sexual behaviour might be impacted. (113)

Caution is warranted when considering phallometric testing to help with diagnostic clarification, as it might depend to some extent on the comprehension and processing of the stimulus provided. Therefore, unless sufficient and convincing information is available, assessors may opt to reserve diagnostic determination instead of focusing on treatment and management recommendations.

Mentally Disordered Sex Offenders

Sexual offences committed by people with major mental disorders can occur during periods of active symptomatology (e.g., mania, depression, intoxication, delusions, hallucinations, obsessions, compulsions) or while the individual is at their baseline mental state. The content of active psychiatric symptoms may or may not be directly

related to the offending behaviour but, rather, viewed more generally as a destabilizing or disinhibiting variable. The content of active psychiatric symptoms may be directly related to the offending behaviour or more generally viewed as a destabilizing or disinhibiting variable. Thus, the evaluator must assess the relative contribution of symptomatology and other motivations to the engagement in sexual aggression. For sex offenders who also have a mental disorder, many factors can impact the assessment and response to treatment, including symptom management, geographic and lifestyle stability, compliance with medication use, mental health supports, and substance use. (114)

Not infrequently, especially for those under provincial and territorial review boards who have been found not criminally responsible on account of mental disorder, the assessor must integrate the role of psychosis in their diagnostic impressions and risk formulation.

When considering whether sexual offending was impacted by active psychosis versus another underlying pathology (such as substance intoxication, personality variables, or paraphilic interests), several areas of in-depth inquiry are required. This includes the evaluee's history and pattern of sexual and nonsexual offending, their mental state during past offences, organization of the behaviour, non-psychotic motivation, and gains derived from the offences. It can be challenging to diagnose a paraphilic disorder in a person who offended only in the context of florid psychosis. In such situations, the forensic assessor reevaluates sexual behaviours once the evaluee's symptoms of major mental disorder have been treated. (115,116)

Approach to Female Sexual Offenders

There are no specific guidelines on how to assess females who have engaged in sexual offending. Given the rarity of this population compared to male sexual offenders, the assessor must take the time to familiarize themselves with the theories of sexual offending in females and tailor their assessment questions accordingly. The paucity of research in this population highlights the limitations of applying sexological assessment models and risk assessment tools developed for males to female sexual offenders. As well, the assessor must be aware of individual and systemic gender biases and stereotypes that might influence how professionals assess and society views such behaviours in females. Tools not specific to sexual offending can be informative (e.g., the PCL-R and structured professional judgement tools), as can personality factors, past sexual behaviour, relationship history, sexual preference, coping strategies, and potential re-offence scenarios. (37)

Transgender Sex Offenders

There is little research on transgender sex offenders, and there are no specific risk assessment tools or guidelines for assessing risk. As with female sex offenders, assessors must be aware of biases and stereotypes that may influence the assessment. Instruments such as the PCL-R and structured professional judgement tools can assist in risk assessments. Sexual preference, personality factors, relationships, past sexual behaviour and offending, coping strategies, and potential re-offence scenarios are, of course, integral to the risk assessment. (117)

Dilemmas

Denial and Minimization

In forensic evaluations, it is not uncommon that an evaluee minimizes or denies the allegations, even after a finding of guilt; sexual violence risk assessments are no exception. In these cases, rendering opinions on diagnosis, risk, and management may require the assessor to rely primarily on file and collateral information; however, although acceptance and insight into offending is a critical aspect of treatment, it is not the only consideration upon which treatment and management success is dependent. Further, denial of offending has not been shown to predict recidivism.

Historical Sexual Offending

Assessors are sometimes asked to evaluate people who committed historical index sexual offences, which only recently have become known. Such cases may prove challenging in many domains, including the accurate and reliable collection of file and collateral information required to render a diagnostic opinion and integrate historical events into future risk assessment predictions. When considering future risk and providing such assessments, evaluators attend to the limitations of risk assessment tools and the incorporation of such variables as additional sexual and nonsexual offending histories and "time offence-free."

Assessment of Treatment and Risk Management Needs

Determining a person's treatment and criminogenic needs starts with understanding the condition(s) and variables that motivated their sexual offending, knowing the standards of treatment and how successful these treatments are in reducing recidivism. Once this has been established, the evaluator applies these principles to the individual's unique circumstances to determine their prospects for treatment and management success. Case-specific factors to consider include the individual's history of treatment engagement, refusal, drop-out, reports by past treatment providers, recidivism after or during courses of treatment, time offence-free within the community, and current willingness to engage in biological and psychological forms of treatment. Management recommendations can include individual and group treatments, medication to reduce sex drive and obsessive thinking, and medication to treat psychiatric illnesses. Management recommendations might also include restrictions, external measures of support,

Table 8. Sample Template for a Clinical Sexual Behaviour Assessment Report

- Referral source and reason for assessment (clinical context and specific referral question)
- Sources of Information
  - Self-report
  - Collateral sources
  - Medical records
- Preliminary caution (confidentiality, duty to warn and disclose, dual role if applicable)
- Identifying data
- Sexual behaviour of concern by evaluee and/or by others
- Relationship and sexual behaviour history (see **Table 1** for an example)
- Prior sexual behaviour treatment and response
- Background history (early history, history of abuse, education and employment, behavioural, legal)
- Psychiatric, substance use, and medical history
- Review of symptoms and mental status examination (including response style and reliability)
- Sexual behaviour testing (as applicable)
- Opinions and recommendations:
  - Summary, including sexual interests and behaviours, sex drive, context
  - Diagnoses—paraphilia(s) (including degree of exclusivity); other DSM-5 disorders; medical disorders, as well as:
    - Level of intelligence
    - Offence-supportive cognitions
    - Coping strategies
  - Motivation for sexual behaviour (predatory, situational vs. preferential behaviour, opportunistic, paraphilic, personality variables, disinhibitors [substances, emotions, mental illness, stress, anger, etc.])
  - Previous response to treatment and treatment readiness (attitudes toward intervention, change, and feasibility of plans)
  - Duty to warn and protect (e.g., child and family services)
  - Treatment and follow-up recommendations
    - For example, to manage social skills, intimacy deficits, offence-supportive cognitions, or sex drive and to enhance strengths (this can include individual or group therapy, sex drive–reducing medication, other medication)
    - To monitor changes over time and provide oversight
- Signature block

Table 9. Example Template for Forensic Sexual Behaviour and Risk Assessment Report

- Referral source and reason for assessment (legal context and specific referral question)
  - For example, pre-sentence assessment; dangerous offender/long-term offender assessment; probation/parole assessment
- Sources of information
  - Legal and medical documents
  - Testing (e.g., medical, sexual preference, standardized psychometric, etc.)
  - Collateral sources
  - Observation (e.g., in custody or on an inpatient unit)
  - Self-report
- Preliminary caution
- Identifying data
- Sexual behaviour of concern (e.g., charges/convictions) by evaluee and (or) others
  - Victim(s) selection, associated factors (substances, stress, weapons), context
  - History of sexual offences (violence, weapons, severity, density, variety, escalation)
  - Cognitions and attitudes about behaviour
- Legal history
- Relationship and sexual behaviour history (see **Table 1** for an example)
- Prior sexual behaviour treatment and response
- Background history (early history, history of abuse, education and employment, behavioural)
- Psychiatric, substance, and medical history
- Review of symptoms and mental status examination (including response style and reliability)
- Sexual behaviour testing
- Risk assessment (as applicable)
  - Actuarial and structured professional judgement tools (e.g., PCL-R, STATIC-99R, SVR-20)
  - Individual risk factors (static and dynamic)
  - Protective factors (e.g., prosocial views, age, treatment cooperation, etc.)
  - Re-offence scenario
- Opinions and recommendations:
  - Summary, including a description of sexual interests and behaviours, sex drive, context
  - Diagnoses—paraphilia(s) (including degree of exclusivity), other DSM-5 disorders, and medical disorders, as well as:
    - Level of intelligence
    - Offence-supportive cognitions
    - Coping strategies
  - Motivation for sexual behaviour (predatory, situational vs. preferential behaviour, opportunistic, paraphilic, personality variables, disinhibitors [substances, emotions, mental illness, stress, anger, etc.])
  - Overall risk assessment (including type of offending, victim pool, context, imminence and severity, potential mitigating factors, special considerations)
    - Probability and severity
  - Previous response to treatment/sanctions and treatment readiness (attitudes toward intervention, change, and feasibility of plans)
  - Other psycholegal issues (duty to warn, child and family services, etc.)
  - Treatment/risk management recommendations (in different contexts)
    - For example, to manage social skills, intimacy deficits, offence-supportive cognitions, sex drive, and comorbidities, such as other mental disorders, substance abuse, and self- and emotion dysregulation; and to enhance strengths (including individual or group therapy, sex drive–reducing medication, other medication)
    - Restriction recommendations (e.g., child-focused areas, social media)
    - To monitor changes over time and provide oversight
- Signature block

monitoring, and supervision required to reduce the risk of recidivism. Factors to determine management needs can include the level of cooperation and rule-abiding behaviours in and out of correctional and probation or parole settings, adherence to rules when not directly supervised, treatment success of underlying conditions, prosocial support system, and engagement in structured risk-neutral or risk-reducing activities.

THE SEXUAL BEHAVIOUR AND RISK OF SEX OFFENDING REPORT (AND TEMPLATES)

There are two major types of reports. One is a clinical sexual behaviour assessment report (for diagnostic and treatment purposes), and the other is a forensic sexual behaviour and risk assessment report (for sex offenders in the legal context). The former focuses on diagnosis and treatment recommendations and is often conducted at the request of another physician. The latter is usually intended to inform non-clinicians in the criminal justice system and will include a risk assessment and recommendations; it is not significantly different in form from nonsexual violence risk assessments.

The form and content of the reports will depend on the sources of information, self-disclosure, and reason for assessment (see Table 8 and Table 9 for examples of templates). The length of the report will depend on the complexity of the matter and the amount of pertinent information available. Forensic reports are longer and more detailed than clinical reports.

The background history of the sexual behaviour assessment is similar to other forensic psychiatry assessments, the focus is on the sexual behaviour of concern (which could be the evaluee's concern or the concern of others, and it could be related to charges and convictions). The forensic assessor will also focus on the evaluee's relationship and sexual behaviour history, associated factors, history of treatment response, treatment readiness, and ability to commit to treatment.

The assessor describes and interprets the risk assessment (if applicable to the evaluation) based on the actuarial and structured professional judgement tools (and inherent limitations, including applicability to the evaluee) and how the evaluee compares to a similar population or even the general population. Individual risk and protective factors are detailed and matched to interventions to reduce risk.

The assessor can describe the type of offending, victim pool, context, imminence, severity, probability of future offending, potential mitigating factors, and special considerations; they can also examine risk in different settings. It can be helpful for the assessor to describe a re-offence scenario in this section that includes when, where, how, and against whom a person might offend.

If conducted, the assessor describes phallometric or other testing results, including limitations and the sensitivity and specificity of testing in the particular laboratory.

Opinions and Recommendations

This section focuses on the nature of, attitudes about, and motivation for the sexual behaviours; reliability of the evaluee's self-report; the evaluee's diagnoses, including paraphilias; and overall risk of sexual re-offence (as applicable). It can also include previous responses to and readiness for treatment. Finally, the assessor describes treatment and risk management recommendations.

Depending on the length of the report, the assessor might include a summary paragraph that focuses on the sexual behaviour (contact or noncontact), interests, drive, and associated factors, as well as the context (victim, setting, if there is grooming) and attitudes. A brief relationship history and functional history might also be described.

The diagnosis section of the report will include any DSM-5 paraphilias with specifiers and the rationale for and against the diagnoses. It can also include other mental illnesses (substance-related, intellectual disabilities or cognitive impairments, major mental illnesses, personality disorders/traits [including level of psychopathy], etc.), and medical illnesses and how these could influence the thinking style, emotions, and behaviour of the evaluee. The forensic assessor might further detail the evaluee's level of intelligence, coping strategies, and offence-supportive cognitions.

The assessor may describe the motivation for the evaluee's sexual behaviour, which might involve paraphilias, personality factors (arrogance and dominance, grandiosity, feelings of inadequacy), and the impact of substances, impulsivity, stressors, anger, and opportunity. Prior treatment, response to treatment, treatment noncompliance, and treatment readiness are noted. Attitudes toward intervention, change, and feasibility of plans can also be described.

Recommendations can include treatment and other interventions (supervision, medication and substance monitoring, follow up). The evaluee's expected response to supervision, group and individual therapy, and medication might also be detailed.

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