THE PATH FROM SEXUAL PREFERENCE DISORDER TO SEX OFFENDER

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Abstract: Studies have shown a clear connection between mental disorders and sexual offenses. Paraphilic disorders (for example sexually sadistic disorders) and personality disorders are noticeably more common in sex offenders than in the general population. In addition to personality disorders, sex offenders also exhibit other psychosocial abnormalities, which distinguishes them from general sexual offenders. In addition to personality disorders, sex offenders also have a paraphilic disorder – sadism. [1] Sexual sadism is described as lustful excitability through control, humiliation or infliction of pain at the expense of another person. This article explains the short path from paraphilia to sexual offenses.

Keywords: Sexual crimes, Personality disorder, Paraphilia, Delinquency.

Introduction

The increased prevalence of mental disorders in offenders compared to the general population is well documented in the literature [2]. The most common diagnoses in sex offenders are personality disorders, substance use and paraphilic disorders [3].

Is there a connection between initial sexual preconception disorders in childhood and subsequent sexual violence or sexually motivated homicide? This could be an approach to the prevention of serious sexual offenses. If psychological deficits in children were recognized at an early stage of development, targeted therapy could prevent worse things from happening later on. The first step is to determine the extent to which an adolescent's experiences and upbringing have an impact later in life. We explore this question and examine how long the path from a sexual preference disorder to sexual offender can be.

Methodology of the research

There is a great deal of information in the existing literature on the subject of mental disorders, sexual offenses and personality disorders. The research method of this article is based on a literature review. As far as possible, current monographs and publications from specialist journals were consulted. The aim was to show how problematic sexual development can arise with the onset of disorders in childhood and the enormous extent to which this can have in later life.

Paraphilic disorders

According to ICD-10, clinically relevant sexual deviations from the norm are summarized as disorders of sexual preference [4]. This term covers the repeated occurrence of intense sexual impulses and fantasies. No distinction is made between sexual preferences that deviate from normative values and disorders that are associated with detrimental consequences for other people. In DSM-5, on the other hand, paraphilic disorders are diagnosed. [5] Paraphilias (from the Greek para, “apart”, “beside”, and philia, “friendship”, “love”) are mental disorders that involve sexual behavior that deviates from the social norm. Here, sexuality is centered on inanimate objects or non-consenting persons – e.g. children – or is associated with pain or humiliation. In contrast to sexual play, they cause clinically significant distress to the person concerned or affect third parties. This, in turn, does not mean that therapy is necessary. Even in the general population, there is a certain acceptance of paraphilias and not always a direct connection with sexual delinquency is assumed [6]. Psychosexual development plays a key role in the development of paraphilic disorders. According to Freud, the development of a person, beginning after birth, in childhood through puberty to adulthood, can be observed in typical phases. According to the model, these phases proceed chronologically as follows: Into an oral phase, anal phase, phallic phase and genital phase. The phase transitions are fluid; if the young person goes through the phases with difficulties due to illness, disturbances caused by environmental influences or parent-child relationship problems, this has an impact on social behavior as an adult. Disorders in the first phase, the oral phase, can lead to illnesses such as schizophrenia, depression and addictive behavior. For example, the loss of a caregiver could be considered a disorder, which could make the child very unstable and unable to bond.

In the second phase of life, the loss of a family member or ongoing parental conflicts can disrupt development. Here, disorders such as stuttering, obsessive-compulsive disorder and paranoia are attributed, which in turn influence the commission of criminal offenses. Offenses ranging from violence and property crimes to murder and sexual perversion – such as sadism – are possible. Later sexual interests originate in the third, phallic phase. If there are disturbances during this phase – the recognition of sexuality – due to strong suppression of sexual interests, this has serious consequences for the child's development. After puberty, the consequences of these fears can lead to relationship inhibitions, with accompanying impotence, neuroses, paraphilias such as pedophilia, sadism and rape, and even murder of the sexual object. In fact, a disturbed childhood can have considerable (late) consequences with criminogenic effects. [7]

Sadism

According to ICD-10 (World Health Organization 2004), sexual sadism is classified as a sexual preference disorder. This means that it must meet the definition of a “disorder of sexual preference”. According to this, a repeated occurrence of intense sexual impulses and fantasies related to unusual objects or activities and acting on these impulses or a clear sense of impairment must be identified. This criterion must exist or have existed for at least six months. In ICD-10, sadism and masochism are combined into one category, resulting in the diagnosis of sadomasochism. In this diagnosis, the sexual activity must involve the infliction of pain, bondage or humiliation. Suffering these sexual practices is referred to as masochism, inflicting them as sadism. However, a distinction must be made in the diagnosis that minor sadomasochistic practices can also be completely acceptable in a regular sexuality life and are not the focus for sexual satisfaction. A direct comparison of the current DSM-5 classifications reveals few changes. For example, sexual sadism, if it is a psychiatric diagnosis, is classified as a sexual sadistic disorder. Sexual arousal must also occur repeatedly and intensely in the patient over a period of at least six months as a result of physical or psychological suffering of another person. In addition, this arousal should manifest itself in fantasies, special behaviors or intense urges. Finally, the urge must have resulted in actions or impairments in important areas of life[8].

The term sadism is encountered in different meanings. In the field of forensic psychiatry, it refers to a compulsive sexual sadistic disorder or sexual sadistic disorder as opposed to consensual sadomasochism and everyday sadism. Sexual sadism is associated with sexually motivated homicide. [9]

Sexual sadism scale

Due to insufficient assessments for a diagnosis of sexual sadism, a list of 17 diagnostically relevant behaviors was initially compiled by a panel of experts, which in turn was further developed through empirical studies into a scale consisting of 11 criteria, the Sexual Sadism Scale (SeSaS) [10].

This scale consists of the following criteria:

- Sexual arousal during offenses
- Exercise of power, control, dominance
- Torturing the victim
- Degrading, humiliating behavior towards the victim
- Mutilation of sexual organs
- Mutilation of other parts or parts of the body
- Exercising excessive physical violence
- Insertion of objects into the victim's orifices

- Ritualized acts
- Locking up the victim/spatial coercion
- Taking trophies [11]

Conclusion

The aim was to show how problematic sexual development can be with the onset of disorders in childhood and the enormous impact this can have later in life. In summary, it can be said that a disturbed childhood can have considerable (late) consequences with criminogenic effects. At the same time, a diagnosis of sexual sadism is often difficult and subject to many factors that can lead to misjudgements. It often depends on the cooperation and motivation of the person affected, the perpetrator, to provide true information. Whether a sexual preference disorder ultimately turns a person into a sex offender must be assessed on a case-by-case basis, as many factors can influence this. With regard to public safety – reducing sexual offenses as much as possible – there is a clear link between sadism and the occurrence of violent and sexual offenses. [12]

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About the Author

Marco Goczol has a master's degree in natural sciences, interdisciplinary expertise and a passionate interest in the psychological-criminological field, not least due to his many years of professional activity and experience in investigating criminal offenses. As a part-time lecturer at the NRW University of Applied Sciences for Police and Administration, he teaches criminalistics with a focus on death investigation, sexual offenses and fire investigation. In his doctoral thesis entitled "Management of information in profiling perpetrators and victims in sexually motivated crimes", he analyzes perpetrator and victim profiles. One thing is certain: it remains difficult to fathom human behavioral patterns.

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