

ASSESSMENT AND MANAGEMENT OF PARAPHILIC DISORDERS

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Executive Summary:

The guideline provides a summary of the assessment and management of paraphilic disorders in adults. It describes the typical diagnostic work-up, including the assessment algorithm. The comprehensive assessment in cases of paraphilic disorders includes risk assessment and risk stratification. Risk stratification divides patients into risk levels so a treatment plan can be tailored accordingly. All treatment modalities fall into Level C or D (described with pharmacological options). The mainstay of non-pharmacological interventions is CBT, which includes Psychoeducation, behavioural analysis, cognitive restructuring, relapse prevention, emotional regulation and social skills training. Pharmacological interventions are SSRIs, CPA, MPA and GnRH agonists. First-line pharmacotherapy includes SSRIs. The dosages of SSRIs should be within the range for OCD. Hormonal management is included from Level 3 onwards, that is, Moderate-High risk / Repeated Offences; the decision to initiate hormonal treatments has to be made after consultation with an endocrinologist. The hormonal treatment should be given if it addresses specific clinical signs, symptoms, and behaviours, or the person's condition represents a significant risk of serious harm to his health or to the physical or moral integrity of other persons and when no less intrusive means of providing care are available. Pharmacological management should always be accompanied by psychological management. Regarding management of comorbidities, serious psychiatric illness needs intervention before the management of paraphilic disorders.

1. INTRODUCTION - DEFINITIONS AND CLASSIFICATION

1.1 Definitions –

Paraphilia - Paraphilias are persistent and recurrent sexual interests, urges, fantasies, or behaviours of marked intensity involving objects, activities, or even situations that are atypical in nature.¹

Paraphilic Disorder - A paraphilia that causes clinically significant distress or functional impairment to the individual, or involves sexual behaviours with non-consenting persons or those who cannot consent.²

Paraphilic Behaviour - Acting on paraphilic urges — may be illegal and harmful to third parties regardless of whether personal distress is present.

1.3 Epidemiology of Paraphilic disorders

Information regarding the prevalence of paraphilias or paraphilic disorders is scarce, and even more so is the case regarding specific paraphilic disorders. Studying prevalence is further hindered by changing diagnostic criteria over time. Different studies have reported prevalence of paraphilia between 1.7 – 62.4%. In a study done in 2017, regarding paraphilic behaviour and interests, almost half of the study population expressed at least one paraphilic interest. They also found that the prevalence of fetishism, frotteurism, voyeurism, and masochism was 15.9%, and the most common paraphilic interests among males were voyeurism and masochism. Joyal and Carpentier in 2017 reported that 45.6% of participants acknowledged at least one paraphilic fantasy, while 33.9% admitted engaging in at least one paraphilic behaviour. In an epidemiological study done on the rural South Indian population, which focused on the prevalence of sexual disorders, no case of paraphilic disorder was identified.^{18,19}

1.2 ICD Nosology of Paraphilic disorders

ICD-6 (1948) and ICD-7 (1958) included the paraphilias as sexual deviations with “other pathological personality disorders. In ICD-8 (1968), these were divided into 8 subcategories, i.e. exhibitionism, voyeurism, fetishism, masochism, pedophilia, transvestism, and homosexuality. Subsequently, homosexuality was eliminated, and transsexuality, sexual dysfunctions, disorders of psychosexual identity (such as gender-role disorder), and ego-dystonic homosexuality were added to the list in ICD-9 (1979). In ICD-10 (1993), sexual sadism and masochism were merged, and these were classified as “Disorder of Sexual Preferences.” Eight categories of paraphilic disorders have been mentioned in ICD-11. A debate is also underway regarding the placement of paraphilias in “other specific and undefined problems with sexual health” as opposed to their current classification among mental diseases

ICD 11 Paraphilic disorder classification ³

Exhibitionistic disorder	6D30	Exposing one’s genitals to an unsuspecting person	Have acted on these thoughts, fantasies or urges, or be markedly

			distressed by them.
Voyeuristic disorder	6D31	Observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity	Have acted on these thoughts, fantasies or urges, or be markedly distressed by them.
Paedophilic disorder	6D32	Sustained, focused and intense pattern of sexual arousal involving pre-pubertal children	Must have acted on these thoughts, fantasies or urges, or be markedly distressed by them.
Coercive sexual sadism disorder	6D33	Sustained, focused and intense pattern of sexual arousal that involves the infliction of physical or psychological suffering on a non-consenting person	Have acted on these thoughts, fantasies or urges, or be markedly distressed by them.
Frotteuristic disorder	6D34	Sustained, focused and intense pattern of sexual arousal that involves touching or rubbing against a non-consenting person	Must have acted on these thoughts, fantasies or urges, or be markedly distressed by them.
Other paraphilic disorder involving non-consenting individuals	6D35	Sustained, focused and intense pattern of atypical sexual arousal in which the focus of the arousal pattern involves others who are unwilling or unable to consent	Must have acted on these thoughts, fantasies or urges, or be markedly distressed by them and arousal pattern is not specifically described by any of the other named paraphilic disorders
Other paraphilic disorder involving solitary behaviour or consenting individuals	6D36	Sustained, focused and intense pattern of atypical sexual arousal that involves consenting adults or solitary behaviour	Either there is marked distress by the nature of the arousal pattern and not simply a consequence of rejection or feared rejection of the arousal pattern by others. Or The nature of the paraphilic behaviour involves significant risk of injury or death either to the or to the individual's partner
Paraphilic disorder, unspecified	6D3Z		

1.3 Differential diagnosis of paraphilic disorders

In making a diagnosis of paraphilic disorders, the first step is to eliminate following disorders as sexual deviation can be a part of such disorders.

Manic episode, major neurocognitive disorder, intellectual developmental disorder, personality change due to another medical condition, substance intoxication, and schizophrenia.

Conduct disorder and antisocial personality disorder

Infliction of physical or psychological suffering during the commission of a sex crime.

2. ASSESSMENT PROTOCOL FOR PATIENT WITH SUSPECTED OR KNOWN PARAPHILIC DISORDER⁴

2.0 Indications for assessment

Assessment is indicated if there is active or imminent risk of harm to self or non-consenting others due to paraphilic urges or behaviour, or there is severe distress, functional impairment, or suicidality related to the paraphilic disorder, or there is failure or non-adherence to outpatient treatment with escalating risk. Assessment is also indicated for court-ordered patients or other forensic psychiatric settings

If there is/are Complex comorbidity/ies (e.g. psychosis, bipolar disorder, severe personality disorder), they require stabilisation before outpatient sexual-behaviour assessment and management

2.1 Primary Assessment

2.1.1 *Demographics and clinical characteristics (From self-report and medical file)*

Age, gender, education level, current or/ and past marital status, number of children (age and gender, if any), current or/ and past employment (with/without children), contacts with children

2.1.2 *Sexual fantasies and behaviour*

Normophilic and paraphilic fantasies/activity (frequency and type); exclusive vs non-exclusive paraphilic behaviour, Age at onset of behaviour and fantasies; type and number of paraphilic disorders, Gender and age of victims; intrafamilial vs extrafamilial victim (known / unknown) Internet/video pornography use (paraphilic or non-paraphilic), Use of violence in association with paraphilic disorder; Previous convictions (sexual and non-sexual offences); history of records in police/justice systems

2.1.3 *Family and personal history*

Family and personal history of sexual disorders, Previous treatment for paraphilic disorders and adherence; alcohol / illicit drug use before paraphilic sexual behaviour; age of puberty, Family and personal psychiatric history, Personality disorders, suicide attempts, brain trauma, Current dementia, intellectual disability, psychiatric / non-psychiatric disease; previous sexual or physical abuse, Use of drugs and substances to enhance sexuality, Misuse of prescription drugs (levodopa etc) Bullying, and developmental

history

2.1.4 Psychological factors

Empathy; coping with stress; impulsivity; interpersonal relationships; insight; motivation for treatment; cognitive distortions (sexuality with children, mutual consent, use of violence); denial; hypersexuality

Assessment protocol for patient with suspected or known paraphilic disorder

Indications for assessment

Active or imminent risk of harm to self or non-consenting others due to paraphilic urges or behaviour

Severe distress, functional impairment, or suicidality related to the paraphilic disorder

Court-ordered or forensic psychiatric evaluation

Complex comorbidity (e.g. psychosis, bipolar disorder, severe personality disorder) requiring stabilisation before outpatient sexual-behaviour treatment

Failure or non-adherence to outpatient treatment with escalating risk

Demographics clinical characteristics (From self-report and medical file)

Age, gender, education level, current and past marital status

Number of children (age and gender, if any)

Current and past employment (with / without children)

Contacts with children

Sexual fantasies s behaviour

Normophilic and paraphilic fantasies / activity (frequency and type); exclusive vs non-exclusive paraphilic behaviour

Age at onset of behaviour and fantasies Type and number of paraphilic disorders

Gender and age of victims; intrafamilial vs extrafamilial victim (known / unknown)

Internet/video pornography use (paraphilic or non-paraphilic)

Use of violence in association with paraphilic disorder;

previous convictions (sexual and non-sexual offences) History of records in police / justice systems

Family and personal history

Family and personal history of sexual disorders

Previous treatment for paraphilic disorders and compliance Alcohol / illicit drug use before paraphilic sexual behaviour Age of puberty

Family and personal psychiatric history

Personality disorders, suicide attempts, brain trauma

Current dementia, intellectual disability, psychiatric / non-psychiatric disease Previous sexual or physical abuse, use of drugs and substances

Psychologic al factors

Empathy; coping with stress; impulsivity, interpersonal relationships; insight Motivation for treatment

Cognitive distortions (sexuality with children, mutual consent, use of violence) Denial; hypersexuality

IF INDICATED, PROCEED TO STRUCTURED HISTORY AND COMPREHENSIVE ASSESSMENT

3. Comprehensive Psychiatric Assessment

3.1 Clinical Interview

Full psychiatric history including onset, nature, and duration of paraphilic interests (minimum 6-month requirement); sexual history: paraphilic fantasy content, frequency, intensity, distress level, behavioral acting-out, victim involvement History of sexual offending or legal involvement, Trauma history including childhood sexual abuse, Substance use history (high comorbidity with paraphilic disorders), Social and occupational functioning, Relationship history and current social supports

3.2. Mental State Examination

Assess for comorbid conditions such as depression, anxiety, OCD-spectrum features, psychosis, mania, personality disorders, ADHD. Also assess impulsivity and impulse control, cognitive distortions related to sexual behaviour, insight and motivation for treatment

3.3 Physical and Medical Assessment

Complete medical history and physical examination, **Hormonal baseline: testosterone (total and free), LH, FSH, prolactin, SHBG**, Metabolic panel: glucose, lipids, liver function (especially if antiandrogen therapy considered), **Bone density (DEXA scan) if long-term GnRH analogue therapy is planned**, BMI, cardiovascular risk assessment, **Neurological examination** if organic aetiology suspected, Sexually transmitted disorder panel (HIV, Hepatitis B and C, syphilis etc), or penile plethysmography

3.4 Psychological Assessment

Psychometric assessment of sexual interests (visual reaction time testing in specialist forensic settings), Personality assessment, Cognitive assessment should include IQ if Intellectual disability is suspected, Neurocognitive assessment to rule out neurocognitive disorders (Frontal assessment battery, MMSE, MOCA, etc)

3.5 Risk Assessment

The following validated instruments should be used to stratify risk in the IPS (inpatient setting):⁴

Instrument	Type	Application in IPS
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Static-99R	Static risk (10 items)	Actuarial recidivism risk at 5, 10, 15 years. Standard tool for adult male sex offenders. Validated across multiple international populations. ⁵
STABLE2007	Dynamic risk (13 items)	Assesses dynamic criminogenic needs including 'deviant sexual interests' and 'sexual preoccupation' subscales — directly useful for severity staging of paraphilic disorders as per WFSBP 2020 guidelines. ^{4,6}
SVR(Sexual violence risk)-20	Structured professional judgment (20 items)	Combines static and dynamic factors. Particularly useful for forensic psychiatric assessment and report writing. ⁷
VRS - SO(Violence Risk Scale-Sexual Offense Version)	Dynamic + treatment change	Assesses criminogenic needs and change from treatment. Preferred for mentally ill offenders where Static-99R alone has limited utility. ^{8,9}
PCL-R (Psychopathy Checklist-Revised) / PCL:SV (Screening version)	Psychopathy	Scores ≥ 25 associated with significantly poorer treatment engagement and outcomes. Scores ≥ 16 warrant cautious application of treatment de-escalation per WFSBP 2020 criteria. ^{4,10}

* Note: As per WFSBP(The World Federation of Societies of Biological Psychiatry (WFSBP)) 2020, a PCL-R score ≥ 16 is a caution flag for treatment de-escalation. Acute severe psychopathology (psychosis, mania, high impulsivity) must be stabilised before initiating paraphilia-specific treatment

** Currently, none of the tools are validated in the Hindi language

4. MANAGEMENT OF PARAPHILIC DISORDERS

4.1 Goals of Management

There are four primary goals for the management of paraphilic disorders; Reduction of problematic sexual behaviors, reduction in sex offending recidivism, increasing adherence to the treatment and management of comorbidities

4.2. PSYCHOTHERAPEUTIC INTERVENTIONS

Psychotherapy is a mandatory component of treatment at ALL levels of the WFSBP treatment algorithm. Pharmacotherapy should never be administered in isolation. The MDT (Multidisciplinary team) should ensure psychological treatment is integrated from the point of admission. These have Level C/D of evidence

4.2.1 Cognitive Behavioural Therapy (CBT)^{14,15}

CBT is the most evidence-supported psychotherapy for paraphilic disorders. In inpatient settings, individual CBT is preferred, with group formats considered as an adjunct where appropriate clinical grouping is possible. **Core components of CBT include: Psychoeducation, Behavioural analysis, Cognitive restructuring, Relapse prevention, Emotional regulation and social skills training.** Psychoeducation components include the nature of paraphilic disorder, cycle of urges and behaviours, and treatment rationale. Behavioural analysis includes functional analysis of the offence and urge cycle — triggers, fantasies, preparatory behaviours, consequences. **Cognitive restructuring** focuses on identification and challenging of cognitive distortions (e.g., victim empathy deficits, minimisation of harm, entitlement schemas)

Relapse prevention should be an integral part of management, as recidivism poses a significant risk in patients with paraphilia; identification of high-risk situations, offence pathway mapping, development of a personalised safety plan. **Emotional regulation** is centred around management of negative emotional states (shame, loneliness, rejection) that often precede paraphilic urges. **Social skills training** addresses interpersonal deficits and enhances appropriate adult relationships

CBT Sessions are delivered in three phases: Acute phase: 2–3 sessions per week, 50–60 minutes per session, Stabilisation phase: 1–2 sessions per week and Pre-discharge phase: weekly, incorporating a relapse prevention focus

CBT for paraphilias focuses on establishing a link between thoughts, emotions and actions, which is followed by correction of the person's abnormal perceptions, irrational beliefs and reasoning biases with respect to specific paraphilic behaviours, CBT should also incorporate self-monitoring and alternate coping strategies to deal with paraphilic urges

4.2.2. Motivational Interviewing (MI)

Many patients with paraphilic disorders present with ambivalence about treatment, particularly pharmacological options with significant side effects. MI techniques should be used throughout admission to build intrinsic motivation for change.

4.2.3 Schema Therapy

Indicated where early maladaptive schemas are identified as maintaining factors — particularly in patients with comorbid personality disorders (narcissistic, antisocial, borderline). Delivered by clinical psychologist.

4.2.4 Mindfulness-Based Approaches

Mindfulness-based relapse prevention (MBRP) adapted for paraphilic urge management. Helps patients develop non-reactive awareness of urges without acting on them ('urge surfing').

4.2.5 Group Therapy

Group therapy should only proceed where appropriate clinical grouping is possible. Contraindicated where patients pose a risk to group members or where paraphilic content may be reinforced by peer interaction. Groups may include: psychoeducational groups, emotion regulation groups, and social skills groups.

4.3. PHARMACOTHERAPEUTIC INTERVENTIONS

Pharmacological Agents	Dosage	Level of evidence
SSRI	Fluoxetine 20–60 mg/day Sertraline 50–200 mg/day Fluvoxamine 100–300 mg/day Paroxetine 20–60 mg/day	Level C
Cyproterone Acetate (CPA)	50–200 mg/day Start 50 mg, titrate to response	Level C
Medroxyprogesterone (MPA)	50- 400 mg/d or 400mg weekly im	Level C
Leuprolide	3.75–7.5 mg SC monthly	Level B/C
Triptorelin	3.75 mg IM monthly	Level B/C
Goserelin	3.6 mg SC monthly	Level B/C

* The dosages of SSRIs are in the range for the management of OCD

Level of evidence - Level A: The evidence for recommendation was obtained from at least three moderately large, positive, randomised, controlled, double-blind trials (RCTs). In addition, at least one of the three studies must be a well-conducted, placebo-controlled study; Level B: The evidence for recommendation was obtained from at least two moderately large, positive, randomised, double-blind trials (this can be either two or more comparator studies or one comparator-controlled and one placebo-controlled study) or from one moderately large, positive, randomised, double-blind study (comparator-controlled or placebo-controlled) and at least one prospective, moderately large (sample size equal to or greater than 50 participants), open-label, naturalistic study; Level C: The evidence for recommendation was obtained from at least one randomised, double-blind study with a comparator treatment and one prospective, open-label study/case series (with a sample of at least 10 participants), or at least two prospective, open-label studies/case series

(with a sample of at least 10 participants) showing efficacy; Level D: Evidence was obtained from expert opinions (from authors and members of the WFSBP Task Force) supported by at least one prospective, open-label study/case series (with a sample of at least 10 participants).

4.3 Monitoring

Evaluation	3 rd Month	6 th Month	12 th Month	Every year
Weight, Height, BMI, BP	✓	✓	✓	✓
Risk of feminization (esp. gynecomastia) Physical examination including genitals, Depression and suicidal thoughts	✓	✓	✓	✓
ECG (CPA)	✓	✓	✓	✓
Thyroid function test, Blood counts, Plasma hormone level (tests): testosterone, testosterone binding protein, luteinizing hormone, prolactin	✓			
Lipid profile Fasting blood glucose levels Calcium and phosphate levels Kidney function test	✓			
LFT	✓	✓ (CPA)	✓ (CPA/GnRH agonist)	✓ (CPA/GnRH agonist)
Lipid profile, Fasting blood glucose levels Calcium and phosphate levels Kidney function test	✓		✓	✓

4.4 Prerequisites for hormonal management of Paraphillias

First, the person has a paraphilic disorder diagnosed by a psychiatrist after a careful psychiatric examination; second, the hormonal treatment addresses specific clinical signs, symptoms, and behaviours and is moderated to the person's state of health; third, the person's condition represents a significant risk of serious harm to his health or to the physical or moral integrity of other persons; fourth, no less intrusive means of providing

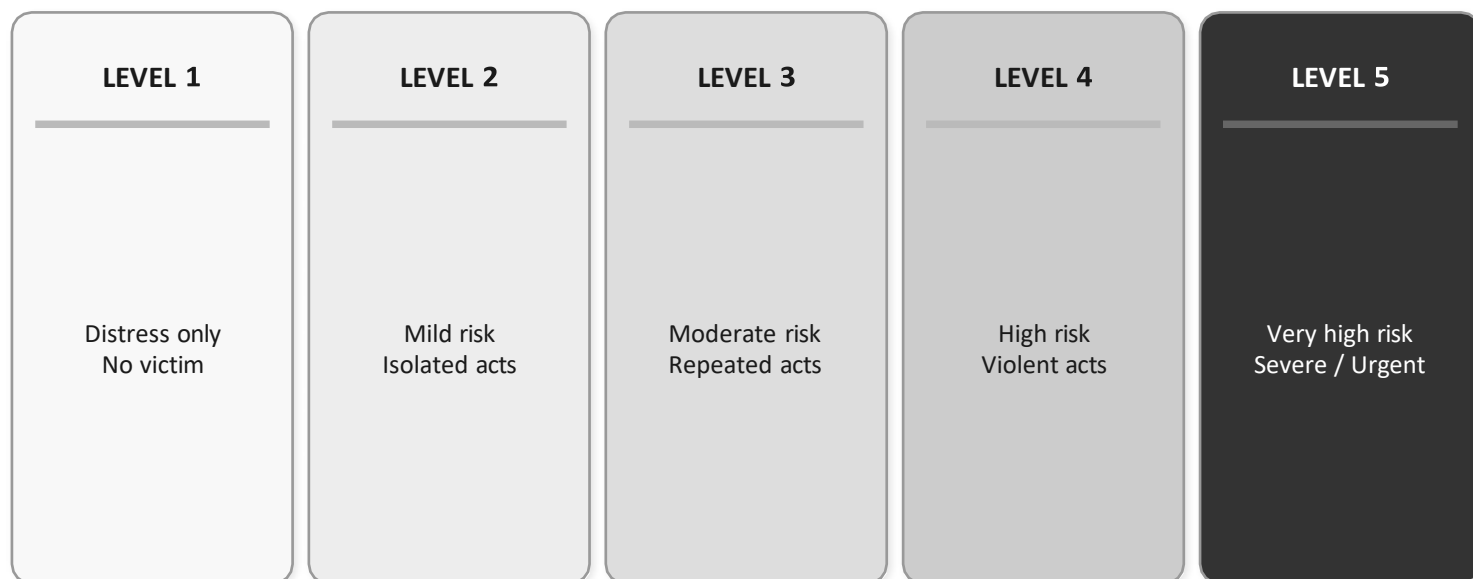
care are available; fifth, the psychiatrist in charge of the patient agrees to inform the patient and receive his or her consent, with the help of a consultant endocrinologist; and last, the hormonal treatment is part of a written treatment plan to be reviewed at appropriate intervals and, if necessary, revised.

Note – The hormonal treatment, if needed, should be done under the guidance and monitoring of an endocrinologist

5. TREATMENT ALGORITHM⁴

Following is the treatment algorithm based on the severity of the paraphilic disorder and the associated risk of harm to others. Treatment is NOT delivered pharmacologically in isolation — psychotherapy is a required component at all levels.

Treatment tier determined by severity and risk level



TIER 1 — Level 1: Low Risk / Distress Only

Pharmacotherapy

- Pharmacotherapy not mandatory
- SSRI (optional) if compulsivity prominent:
 - Fluoxetine 20–60 mg/day
 - Sertraline 50–200 mg/day
 - Fluvoxamine 100–300 mg/day
 - Paroxetine 20–60 mg/day

Psychotherapy

- Cognitive Behavioural Therapy (CBT)
- Relapse prevention
- Motivational enhancement
- Psychoeducation
- Offence cycle analysis

Monitoring

- Monthly clinical review
- SSRI side effect screening
- Depression screening
- Reassess risk at 12 weeks

TIER 2 — Level 2: Moderate / Isolated Offences

Pharmacotherapy

- First-line pharmacotherapy:
 - Fluoxetine 20–60 mg/day
 - Sertraline 50–200 mg/day
 - Paroxetine 20–60 mg/day
 - Fluvoxamine 100–300 mg/day
- Note: higher than standard antidepressant doses required
- Adequate trial: 8–12 weeks minimum

Psychotherapy

- CBT — mandatory
- Relapse prevention
- Social skills training
- Motivational interviewing
- Regular offence cycle review

Monitoring

- Monthly clinical review
- SSRI side effects (sexual dysfunction, GI, insomnia)
- Response assessment at 12 weeks
- Risk reassessment if no response

Level 3 — Moderate-High risk / Repeated Offences

Pharmacotherapy

Oral testosterone-lowering agents:

Cyproterone Acetate (CPA)

50–200 mg/day Start 50 mg, titrate to response

Medroxyprogesterone

(MPA) 50- 400 mg/d or i.m, 400mg weekly and then monthly if CPA is not available

Mechanism: androgen receptor blockade^{4,12} + central LH suppression (CPA)

Add SSRI for residual compulsivity

GnRH agonist may be used if serious side effects are noted with CPA and MPA

Psychotherapy

CBT — mandatory throughout

Psychotherapy must continue concurrently with pharmacotherapy

Group therapy if available

Monitoring

Baseline: LFT, testosterone, LH/FSH,

PSA (>40 yrs), bone density

Testosterone level monthly for first 3 months then every 3 months

Liver function: baseline, 3 months, 6 months, then 6-monthly (cpa)

DEXA scan at 12 months and annually if long treatment

Monitor: depression, gynaecomastia, thromboembolism

*Hormonal treatment should be initiated after consultation with an endocrinologist.

Level 4 — High Risk / Serious Offences / Violence

Pharmacotherapy	Psychotherapy	Monitoring
Long-acting GnRH agonist i.e. triptorelin or leuprolide acetate 3 or 3.75 mg/month or 11.25mg i.m every 3 months. CPA must be associated with GnRH agonist (1 week before and during the 1st month of GnRH agonist treatment) to prevent flare effect and to control the relapse risk of paraphilic sexual behavior associated with this flare-up effect.^{4,13}	Structured CBT programme Forensic psychiatric review Victim safety management plan Multidisciplinary team (MDT) review	LFT every 3 months Bone density (DEXA at 1 year) Cardiovascular risk monitoring Screen for depression at every visit

*Hormonal treatment should be initiated after consultation with an endocrinologist.

Level 5 — Very High Risk / Severe / Treatment-Resistant

Pharmacotherapy

GnRH agonists (most potent):
Leuprolide 3.75–7.5 mg SC monthly
Triptorelin 3.75 mg IM monthly
Goserelin 3.6 mg SC monthly
In addition to GnRH agonist use antiandrogen treatment, i.e.:
CPA oral 50–200mg/d (max 300mg) or MPA 50–400mg/d or 400mg i.m weekly and then monthly if CPA not available.
SSRI may also be added.

Psychotherapy

Intensive structured CBT
Forensic psychiatric review at every visit
Inpatient management if imminently Dangerous
Victim safety plan

Monitoring

Testosterone monthly (<50 ng/dL)
Bone density DEXA — baseline then annual (osteoporosis risk)
PSA annually (>40 years)
Lipid profile, cardiovascular
Hot flashes, depression screening

■ **EMERGENCY — IMMINENT HIGH RISK**

Active urges with accessible victim → Immediate Tier 5 | CPA oral STAT | Initiate GnRH analogue | Psychiatric admission | Victim safety plan documented

5.2 Agents with very poor or limited evidence

Antipsychotics

Lithium

Anticonvulsants - Sodium valproate, Carbamazepine

Naltrexone etc.

6. Management of Comorbid Psychiatric Conditions

6.1 Comorbid psychiatric conditions are common in patients with paraphilic disorders and must be treated concurrently. Their presence may complicate treatment and influence prognosis.

Comorbidity	Prevalence / Notes	In-Patient Management Priorities
Depression	High — may be primary or secondary to shame about paraphilic disorder or medication side effects	Antidepressant (SSRI first-line — serves dual purpose). Regular mood monitoring. Suicide risk assessment.
Anxiety / OCD Spectrum	Paraphilic urges often have obsessional quality; OCD comorbidity well documented	SSRI doses at higher OCD-range and CBT components within framework of ERP
Substance use Disorders	Alcohol and stimulant misuse disinhibit paraphilic behaviors; high comorbidity	Concurrent SUD treatment mandatory. Substance use is a dynamic risk factor — active use significantly elevates offense risk.
Personality Disorders	Antisocial and narcissistic PD associated with poorer treatment outcomes; borderline PD also common	Schema therapy. DBT for borderline PD. PCL-R scoring. Adjust treatment expectations.
Bipolar Disorder	Manic/hypomanic episodes may markedly disinhibit paraphilic behavior	Mood stabilizer (lithium, valproate, or quetiapine) mandatory. Do not initiate paraphilia-specific pharmacotherapy until mood stabilized.
Psychotic Disorders	Rare primary association but psychosis significantly impairs treatment engagement	Antipsychotic stabilization before commencing paraphilia-focused treatment. Note: some antipsychotics have mild antiandrogen effects.
Intellectual Disability	Requires adapted assessments and treatment approaches	Simplified psychoeducation. Adapted CBT. Consider specialist ID-forensic liaison.

6.2 Duration of treatment

SSRIs: minimum 12 months for initial treatment; longer-term continuation based on clinical response and risk

Oral antiandrogens (CPA/MPA): minimum 24 months in high-risk cases; taper only with MDT consensus and documented risk reduction

GnRH analogues: minimum 24–36 months for severe/very high-risk cases; annual specialist review required for continuation beyond 3 years

Cessation of antiandrogen or GnRH analogue therapy should only occur after documented sustained risk reduction, with a clear monitoring plan in place

7. SPECIAL POPULATIONS AND CONSIDERATIONS

7.1 Adolescents (Under 18)

This guideline applies to adults (≥ 18 years) only and so, for adolescent presentations, other available guidelines should be followed

7.2 Female Patients

The guidelines focus predominantly on adult males (reflecting the epidemiology of paraphilic disorders). For female patients, treatment should be individualised; pharmacological options may differ and require collaboration with an endocrinologist. Risk assessment tools also need validation and standardisation for use in females

7.3 Patients with Intellectual Disability

Adapted assessment tools are required (e.g., Assessment of Risk and Manageability for Individuals with Developmental and Intellectual Limitations who Offend Sexually — ARMIDILO-S) (not validated in the Indian population). Therapies need to be adapted to the cognitive level of the person. Capacity assessment (and supported decision-making) is required before any pharmacological treatment

7.4 Forensic / Court-Ordered Patients

Forensic patients may be subject to additional legal requirements; treating clinician should liaise with legal representatives and court where needed. Confidentiality limits must be clearly explained at admission: information may be disclosed to courts and other relevant agencies, and the treatment refusal in a forensic context must be managed in accordance with the Mental Health Care Act 2017 within the legal framework.

8. MONITORING, DOCUMENTATION, AND AUDIT AND CLINICAL DOCUMENTATION STANDARDS

All assessments, risk formulations, MDT decisions, consent discussions, and treatment reviews must be documented contemporaneously in the clinical record. Risk assessment scores must be recorded at admission, at 3-monthly intervals during admission, and at discharge. All pharmacotherapy prescriptions must include documented indication, informed consent reference, baseline investigations, and monitoring plan. Any incident involving paraphilic behaviour during admission must be recorded as a clinical incident and trigger urgent review

9. Forensic aspects of paraphilic disorders

The presence of paraphilic disorders is neither illegal nor a crime, but when it involves non-consenting partners or persons owing to acting on urges, person may be subjected to legal consequences.

Laws related to paraphillias in India are¹⁴

No.	Paraphilia	Section	Description	Punishment
1.	Voyeurism	IPC 354C	Any man who watches or captures the image of a woman engaging in a private act in circumstances where she would usually have the expectation of not being observed either by the perpetrator or by any other person at the behest of the perpetrator or disseminates such image shall be punished	First Conviction: Imprisonment is a minimum of 1 year and may extend to 3 years with a fine. Subsequent Conviction: Imprisonment is a minimum of 3 years and may extend to 7 years with a fine.
2.	Exhibitionism	No specific section is mentioned	Not described	As per POCSO Act, 2012, ⁴² if exhibitionism in front of minors ranging from 3 years to life imprisonment
3.	Pedophilia	POCSO Act, (2019)	A sustained, focused, and intense pattern of sexual arousal as manifested by persistent sexual thoughts, fantasies, urges, or behaviors involving pre-pubertal children and individuals must have acted on these thoughts, fantasies, or urges or be markedly distressed by them.	As per POCSO Act, 2012 ⁴² ranging from 3 years till life imprisonment
4.	Frotteuristic disorder (covered under various acts, though the exact term of frotteurism is not mentioned in the IPC or POCSO act)	IPC 354 IPC 509 IPC 268	Assault or criminal force to a woman with intent to outrage her modesty. Word, gesture, or act intended to insult the modesty of a woman Cases of public nuisance	Imprisonment is a minimum of 1 year and may extend to 5 years with a fine. Imprisonment is a minimum term and may extend to 3 years with a fine.
5.	Sexual sadism (BDSM)	Legal status		Legalized in India ⁴⁴
6.	Bestiality/ zoophilia Necrophilia	IPC 377	Unnatural sexual offences	Imprisonment of either description for a term extending to 10 years shall also be liable to a fine.

Key References

1. Fisher KA, Marwaha R. Paraphilia. [Updated 2023 Mar 6]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2026 Jan.
 2. American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.):779- 802
 3. World Health Organization. International Classification of Diseases, 11th Revision (ICD-11). Geneva: WHO; 2024.
 4. Thibaut F, Cosyns P, Fedoroff JP, Briken P, Goethals K, Bradford JMW and The WFSBP Task Force on Paraphilias. The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the pharmacological treatment of paraphilic disorders. *World Journal of Biological Psychiatry*. 2020;21(6):412–490.
 5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). Washington DC: APA Publishing; 2022.
 6. Thibaut F, De La Barra F, Gordon H, Cosyns P, Bradford JMW and WFSBP Task Force on Sexual Disorders. The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the biological treatment of paraphilias. *World Journal of Biological Psychiatry*. 2010;11(4):604–655.
 7. Culos C, Di Grazia M, Meneguzzo P. Pharmacological Interventions in Paraphilic Disorders: Systematic Review and Insights. *Journal of Clinical Medicine*. 2024;13(6):1524. DOI: 10.3390/jcm13061524.
 8. Shumate JN, Song SH, Saleh FM. Paraphilic disorders, psychopathy, and those who sexually offend: a narrative review of treatment modalities. *International Journal of Impotence Research*. 2025;37(3):179–185.
 9. First MB. DSM-5 and Paraphilic Disorders. *Journal of the American Academy of Psychiatry and the Law*. 2014;42(2):191–201.
 10. Briken P, Fedoroff JP, Bradford JMW. The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the treatment of adolescent sexual offenders with paraphilic disorders. *World Journal of Biological Psychiatry*. 2014;15(5):364–375.
 11. PÆv M, Sebaló I, Briche n S, Perkins D. Outcome Evaluation of a Treatment Program for Men with Paraphilic Disorders Convicted of Sexual Offenses: 10-Year Community Follow-up. *International Journal of Offender Therapy and Comparative Criminology*. 2023. DOI: 10.1177/0306624X231165416.
 12. Holoyda BJ, Kellaher DC. The Biological Treatment of Paraphilic Disorders: An Updated Review. *Current Psychiatry Reports*. 2016;18(2):19. DOI: 10.1007/s11920-015-0649-y.
 13. Kesarwani, T. and Gupta, C. (2024). Comprehensive Review on Paraphilic Tendencies Among Indian Females Adults. *International Journal of Indian Psychology*, 12(2), 259-269. DIP:18.01.026.20241202, DOI:10.25215/1202.026
 14. *Indian J Psychol Med*. 2024 Aug 1;47(6):539–548. doi: 10.1177/02537176241256885 Narrative Review of Paraphilias: An Indian Perspective Manish Roshan Thakur 1,✉, Ravi Yadav 1, Rajvardhan Singh Bhanwar 2
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16. Sathyanarayana Rao TS, Avasthi A. Roadmap for sexual medicine: Agenda for Indian Psychiatric Society. *Indian J Psychiatry* 2008;50:153-4.
 17. Rao TSS, Tandon A, Manohar S, Mathur S. Clinical Practice Guidelines for management of Sexual Disorders in Elderly. *Indian J Psychiatry*. 2018 Feb;60(Suppl 3): S397D409.
 18. Joyal CC, Carpentier J. The Prevalence of Paraphilic Interests and Behaviors in the General Population: A Provincial Survey. *J Sex Res*. 2017 Feb;54(2):161-171.
 19. Sathyanarayana Rao TS, Darshan MS, Tandon A. An epidemiological study of sexual disorders in south Indian rural population. *Indian J Psychiatry*. 2015 Apr-Jun;57(2):150-7. doi: 10.4103/0019-5545.158143. PMID: 26124520; PMCID: PMC4462783.
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