CASE REPORT

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Simulated Paraphilias: A Preliminary Study of Patients Who Imitate or Exaggerate Paraphilic Symptoms and Behaviors

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ABSTRACT: In a consecutive series of admissions to the Johns Hopkins Sexual Disorders Unit, 4 out of 20 patients appeared to have simulated paraphilic symptoms that further assessment indicated were either exaggerated or not present. The paper presents case histories of these 4 patients. A descriptive comparison is made between these patients and control groups of patients who admitted having paraphilic symptoms and a group of patients accused of having paraphilic symptoms but who denied them. Patients who simulated paraphilias tended to be self-referred (75%) and without current legal charges (100%). None of these patients was referred or sought treatment for pedophilia, in contrast to the other two patient groups, in which pedophilia accounted for 75% of the referrals. Several possible explanations for why patients might simulate paraphilias and implications for therapists who evaluate or treat sex offenders are discussed.

KEYWORDS: psychiatry, criminal sex offenses, paraphilia, simulation, sex offenders, factitious disorders

Sex offenders are a heterogeneous patient group with at least nine separate paraphilias listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) [*1*], while other authorities have described far more [*2*]. Even within a single diagnostic category (for example, pedophilia), there are many possible presentations and etiologies that have yet to be fully investigated. One of the main difficulties that investigators face is the

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problem of verifying the data collected about the sexual behavior of sex offenders. There are several ways in which data can become misleading. First, paraphilic subjects may deny that they have paraphilic symptoms or behaviors. The motivation to deny engaging in paraphilic behaviors is quite understandable since this may help avoid embarrassment or criminal prosecution or both. The issue of defensiveness and denial in sex offenders has recently been reviewed by Langevin [*3*], who concluded that considerable care should be exercised in ruling out deception. In general, deception takes the form of denying that paraphilic symptoms are present.

Abel et al. [*4*] attempted to overcome this problem by taking elaborate measures to ensure the confidentiality of paraphilic mens' responses to questions about the frequency of their deviant sexual behaviors. That study found that the number of paraphilic acts reported by study participants was much greater than previous estimates. When the validity of the subjects' self-reports was checked by comparing the self-reports to the subjects' arrest records, the frequency of self-reported crimes was much greater than the number of crimes for which the subjects had been arrested. The conclusion was that the reported frequency of paraphilic acts was, if anything, an underestimate of their true frequency.

However, an alternative explanation is that, at least in some cases, subjects exaggerated the frequency or nature of their sexual exploits. There have been several studies concerning the frequency of false claims of sex abuse, but to our knowledge these have all involved situations in which sex abuse has been falsely reported either by a child or another adult but denied by the accused [*5*]. To our knowledge, a case has never been reported in which a patient intentionally attempted to produce false or exaggerated symptoms of a paraphilia.

There is no diagnostic term to describe the act of imitating symptoms of a psychiatric disorder that does not imply some knowledge of whether or not the act is done intentionally or for some external incentive. For example, the DSM-III-R defines malingering as the intentional production of false or grossly exaggerated symptoms motivated by external incentives [*1*, p. 360]. Factitious disorders are defined as the intentional production or feigning of symptoms together with the psychological need to assume the sick role as evidenced by the absence of external incentives for the behavior [*1*, p. 315]. Unfortunately, it is not always easy to be sure how intentional or how external a particular behavior or incentive is. These and other problems with current diagnostic criteria have been well described [*6*]. For these reasons, the term *simulation* will be used to refer to the act of imitating or exaggerating symptoms or behaviors that the patient does not in fact have. The purpose of this paper is to report on our experience with patients who appear to have simulated paraphilic symptoms that they do *not* have.

Methods

All inpatients admitted to the Johns Hopkins Sexual Disorders Unit (JHSDU) during a 2-month period were included in this study. The JHSDU is assigned 8 beds in a 22-bed general psychiatry ward. The unit specializes in evaluating and treating patients with paraphilias. As part of their routine initial assessment, all patients were given a standardized, semistructured psychiatric interview and physical exam by the admitting psychiatry resident (AH, MM). Any available legal reports regarding past or present sex offense charges are routinely obtained for all admissions. In addition, each patient was given an extensive, independent psychiatric interview by the attending psychiatrist (JPF). Consensus diagnoses of the patient's sexual disorder were made according to DSM-III-R criteria based on the two independent psychiatric interviews, all past medical, psychiatric and legal reports, and assessment with penile plethysmography (HMM). Physical examinations and testosterone levels were also obtained on all patients to rule out other

medical conditions. Attempts were made whenever possible to interview spouses or other family members of each patient. There were 20 patients admitted to the unit during this time.

All records were reviewed retrospectively and patients were divided into 3 groups: patients who admitted having paraphilic interests compatible with their diagnoses (Confessors $n = 13$), patients who denied any paraphilic interests or activities (Deniers $n = 3$) and patients who claimed to have paraphilias or an increased sex drive for which the treatment team could find little or no evidence (Simulators $n = 4$). Since patients who attempt to simulate paraphilias have never been previously described, detailed case histories of the 4 patients in the Simulator Group are presented below.

Case A

Case A is a 38-year-old unemployed single male who had one prior JHSDU admission when he was referred by his therapist at another center for assessment after he spontaneously confessed to a lifelong sexual interest in prepubertal boys. His therapist had been treating him with psychotherapy for dysthymic disorder in weekly sessions for 6 years. To our knowledge the therapist had not previously suspected that the patient had any paraphilias.

The patient's family history was notable for alcoholism in the patient's father and suicide in the patient's older brother. The patient's personal history was significant for the absence of any medical or psychiatric difficulties as a child. He was able to complete Grade 11 before he left school because of "disagreements" with his teacher, about which he refused to elaborate. During his first JHSDU admission he reported being sexually abused at age 14 by a 16-year-old boy and again at age 18 by two 18-year-old boys. He never had any sexual experiences or fantasies about women, and had only had sexual relations with boys. Although his sexual behavior and fantasies were directed only toward males, he resisted labelling himself as homosexual. In his twenties, he became alcoholic. During a drinking spree he had fallen and was placed on medical disability, which became his only means of financial support.

Shortly afterward he stopped drinking alcohol and sought treatment for dysthymia. He lived a sequestered life but he became very involved in the Boy Scouts of America and was a respected Boy Scout leader. His medical disability did not prevent him from participating in the usual Boy Scout activities, including frequent camping expeditions with boys. During his first admission to the JHSDU (which occurred before the initiation of this study) he showed no signs of an affective disorder, and no abnormalities were found on physical examination. A radiologic examination of his coccyx was reported as completely normal. Sexual response patterns on penile plethysmography were compatible with the diagnosis of homosexual pedophilia with maximum sexual arousal toward boys in the age range of 7 to 14 years. He was given a diagnosis of homosexual pedophilia and he was prescribed weekly doses of medroxyprogesterone, 500 mg intramuscular. A diagnosis of malingered physical disability (damaged coccyx) was also made.

During the course of his first inpatient assessment he was found to be a superficially charming, sensitive, and immature man who made friends easily with other sex offenders. He participated in group therapy for sex offenders with reluctance, often attempting to miss sessions by taking elderly patients on the general psychiatry service for walks. He reported an excellent response to medroxyprogesterone, saying he noticed an almost immediate diminution in all sexual fantasies, which was confirmed by a decrease in sexual responses to pedophilic stimuli on followup plethysmography five weeks after beginning anti-androgen treatment. While on the ward he befriended another male mentally retarded adult sex offender, who was charged with sexual relations with farm animals (zoophilia). These two men were noted by the nursing staff frequently to be found in

conversation in the evenings. He appeared to enjoy the institutional setting and became angry whenever the issue of employment was raised, insisting he was permanently disabled because of his coccyx.

He was discharged after 16 days on medroxyprogesterone with arrangements for him to continue in outpatient group psychotherapy in a sex offender group in addition to continuing outpatient individual psychotherapy for possible dysthymic disorder with his referring therapist. He agreed to resign from the Boy Scout movement, and the fact was verified that Protective Services had been made aware of his past pedophilic activity. He was also discouraged from his wish to volunteer for work in the hospital.

Shortly after discharge, the patient called the ward to report that he was now overwhelmed by sexual urges toward pigs and cows. He demanded immediate readmission to the ward and suggested that his medroxyprogesterone dose be increased. Because of concerns that the patient was decompensating he was readmitted to the ward for evaluation and treatment and was included in the present study at this time.

On admission he was found to be unchanged from his condition at the time of his last discharge one month earlier with the exception that he now claimed to have no sexual thoughts involving children, these having been entirely replaced by zoophilic fantasies. A repeat plethysmography evaluation that included stimuli involving pigs (his stated most sexually arousing animal) failed to show any change in his sexual response patterns from those at the time of his most recent discharge and no sexual response to animals.

Summary—This is a patient with ego-dystonic homosexuality, homosexual pedophilia, and suspected malingering to obtain disability payments for a damaged coccyx. While in the JHSDU he learned that sex with children but not animals is reportable. The novel appearance of complaints about irresistible impulses to have sex with animals that could not be confirmed by plethysmography, together with requests for readmission to hospital, suggest that this patient's zoophilic complaints were indeed simulated.

Case B

Case B is a 36-year-old separated, self-employed man who stated that he had a "sex addiction due to a chemical imbalance." He referred himself to the JHSDU after reading about treatment with medroxyprogesterone in a newspaper and presented the unusual complaint that he felt driven to spend large amounts of money on "muscular (female) prostitutes." As a result, he said his wife was threatening to divorce him, and he was on the verge of financial ruin. He identified his problem as completely sexual in nature although he never had sex with any of the prostitutes he was involved with, saying he preferred to wrestle with all participants fully clothed.

There was no family history of psychiatric illness aside from alcoholism on the paternal side of the family. He had no early developmental problems except for enuresis to the age of ten, which resolved without treatment. Although he said his father was physically abusive, the patient was never sexually abused and never required hospitalization or missed a day of school. He had no school problems and had completed a B.A. He was employed in a very lucrative family business, which had given him the financial resources to pursue his unusual sexual adventures. On one occasion he claimed to have spent $2000 in one night, which involved hiring two particularly muscular and masculine women to wrestle with him. His psychiatric history was remarkable for his pattern of voluntarily going directly from one psychiatric hospital to another, usually in different cities. In fact, on the day of his admission to the JHSDU he already had a "reservation" to check into another treatment facility that he had scheduled to begin following his discharge from our unit. He had never had a psychiatric hospital admission that he had not scheduled in advance.

He also reported a long history of polysubstance abuse but he adamantly denied even considering any intravenous drug abuse since he felt it was too dangerous. He was particularly frightened by the possibility of contracting acquired immunodeficiency syndrome (AIDS). The drug he most preferred was cocaine and he said he was unable to engage in sexual activity of any kind unless he was intoxicated. He did not have sex with his wife and said that he rarely was able to get an erection.

In spite of being in psychotherapy for years which focused on his substance dependence, he had never been diagnosed with an Axis I psychiatric disorder, nor had he ever taken psychotropic medications until just before his self-referral to the JHSDU when a psychiatrist at another hospital diagnosed him as having bipolar disorder and treated him with fluoxetine 20 mg three times a day (tid) and clonazepam 0.5 mg tid. The patient reported that he felt more anxious on these medications.

On admission, he was found to be an anxious, neatly groomed man who used psychological jargon and endorsed practically any unusual psychiatric symptom that was suggested. In response to questions about sexual orientation, he was particularly adamant in his denial of any homosexual experiences or fantasies. He was very well informed and concerned about AIDS. On careful examination he failed to meet full criteria for any Axis I psychiatric condition aside from cocaine dependency.

In hospital he was rapidly tapered from both clonazepam and fluoxetine without difficulty and with an improvement in his symptoms of anxiety. He participated enthusiastically in all ward activities and was quick to champion the cause of other patients who he felt were not getting enough attention. However, he was very angry at the staff's reluctance to start him on medroxyprogesterone before his assessment had been completed. At one point he threatened to leave the hospital and hire a prostitute to prove to the staff that he needed sex drive-reducing medication.

On penile plethysmography he unexpectedly demonstrated a sexual response pattern most consistent with that of adult homosexuality with no paraphilic sexual arousal patterns. He did not show any heterosexual arousal. When the results of his assessment were reviewed with him, the patient tearfully admitted having frequent homosexual fantasies that he had previously denied. The remainder of his treatment focused on helping the patient to acknowledge and discuss his homosexual feelings with a subsequent decline in his reported urges to hire female prostitutes. Because of his anxiety concerning this topic and our previous success in treating paraphilic patients who had prominent anxiety symptoms with buspirone [7], he was begun on buspirone 5 mg tid. He was discharged after 20 days with a marked decrease in all his anxiety symptoms or urges to contact female prostitutes.

Summary—This patient did not have a paraphilia but did have ego-dystonic homosexuality. He claimed to have symptoms suggestive of an atypical heterosexual paraphilia (compulsive sexual activity involving wrestling with muscular women). However, on assessment with penile plethysmography he was shown to have only nonparaphilic adult homosexual arousal. His symptoms appear to have been simulated for the purpose of convincing his doctors to prescribe anti-androgen medication. In fact, he threatened to act out his "paraphilic" behavior if he was not placed on medroxyprogesterone. Whether or not he had ever actually wrestled with any prostitutes is unknown, but his reported sexual arousal only to women and not men was admitted by the patient to have been a misrepresentation of the facts.

Case C

Case C is a 27-year-old single unemployed man who was self-referred with a chief complaint of male erectile disorder and exhibitionism. The patient's family history was notable for untreated obsessive-compulsive disorder in the patient's father but no other known or suspected psychiatric disorders. The patient's personal history was entirely

normal until high school when he became heavily involved in nonintravenous polysubstance abuse with his preferred drugs of abuse being alcohol and marihuana. With some difficulty he had completed high school and one year of college although his grades had deteriorated in the context of his increasing drug use, which had also precluded his ability to maintain steady employment. Socially, he claimed to have no trouble attracting girlfriends but resisted sexual intercourse because of difficulty achieving an erection. In addition, he had a lifelong problem in maintaining a committed relationship, the longest being a month in duration. On admission he denied any history of sexual or physical abuse. He had no medical problems aside from mild glaucoma, but he admitted to being preoccupied with his physical health and frequently worried that he had undiagnosed physical illnesses. He had not had any psychiatric treatment until five months before this admission, when he was admitted to another hospital for alcohol detoxification and evaluation for major depression. Following that admission, the patient reported that his feelings of anxiety increased. During this time, he said he began masturbating in parking lots in his truck while watching people walk by. He was particularly evasive about what sort of people excited him most. He insisted he was an exhibitionist, but during his admission interview he adamantly denied any attempt or desire to be seen by anyone for the purposes of sexual arousal.

In the months that followed, his behavior escalated to the point that two neighborhood girls reported him to their father when they saw him masturbating in his ground floor bedroom with the curtains open. No criminal charges were pressed, but the patient and his parents were sufficiently concerned to seek assessment in our unit.

On admission the patient was found to be very anxious, particularly about the possibility of being on a ward with sex offenders. He was extremely secretive and mortified by our request that he allow us to interview his parents or current girlfriend. He seemed especially interested in the possibility that he might have a medical illness that was interfering in his ability to achieve an erection. His psychiatric and physical examination was unremarkable except for the discovery of obsessive compulsive counting and touching rituals which had been undetected on his previous psychiatric admission.

Results of his penile plethysmography indicated that he was able to achieve full erections only when presented with pedophilic stimuli involving young boys and girls who were in early stages of puberty (that is, a bisexual ephebophilic sexual response pattern). When he was presented with the results of our assessment, the patient reluctantly admitted that his sexual fantasies involved only ephebophilic themes and not exhibitionistic themes. He also spontaneously reported a three-year history of weekly sexual abuse during his adolescence by older neighborhood teenage boys. He was begun on medroxyprogesterone and buspirone with improvement in both paraphilic and obsessive-compulsive symptoms.

Summary—This is a patient with classic ephebophilia (in fact reliving his own sexual exploitation as an adolescent). When he was caught in the act of making sexual overtures toward two girls he claimed he was an exhibitionist rather than admit he was sexually attracted to the girls. At no time was there any indication that the patient met diagnostic criteria for exhibitionism which requires the presence of recurrent and intense sexual urges and fantasies involving genital exposure to unsuspecting strangers [*1*, p. 282]. He did in fact meet criteria for a variant of pedophilia known as heterosexual ephebophilia—sexual arousal to puberal boys and girls. His attempts to mislead the treatment staff into making the diagnosis of a nonreportable (and to his mind more socially acceptable) sexual disorder by reporting only those behaviors that he thought would result in a diagnosis of exhibitionism suggest that he was simulating exhibitionism.

Case D

Case D is a 37-year-old single, unemployed male who was referred from his outpatient sex offender group because of a reoccurrence of his exhibitionism. Important aspects of

his family history included exhibitionism in a maternal uncle as well as a history of schizophrenia in the patient's maternal grandmother and alcohol abuse in the patient's mother. His personal history indicated that he had completed Grade 12 but had never been steadily employed. He had never married and had few romantic relationships with adult women. Although he had no significant medical illnesses he had an extensive psychiatric history. He was first arrested at age 16 for exhibitionism and since then had numerous convictions for this offense. His first admission to a psychiatric hospital occurred at age 21 when he complained of auditory hallucinations. He was diagnosed as having paranoid schizophrenia and treated with neuroleptic medication. He also had a lifelong history of nonintravenous drug and alcohol dependency. On a previous admission to an inpatient unit of the general psychiatry division of the Johns Hopkins psychiatry department, his diagnosis of schizophrenia was questioned. He intentionally exhibited himself to one of the patients on hearing that he was about to be discharged.

On the current admission, the patient complained again of auditory hallucinations, and so he was restarted on intramuscular fluphenazine with an improvement in his psychotic symptoms. In addition, he was continued on intramuscular medroxyprogesterone because of his recent exacerbation of exhibitionism. However, the primary focus of his therapy was his alcohol dependency, which clearly interfered with his ability to benefit from any other therapy. His schizophrenic and paraphilic symptoms showed a prompt improvement as soon as he was admitted to the ward. However, on the day he was informed of his upcoming discharge, he reported a sudden exacerbation of urges to exhibit himself as well as a return of his auditory hallucinations. Because of his inability to assure us of his participation in therapy for possible schizophrenia, paraphilia, or alcohol dependency he was reluctantly discharged from our clinic to one that could focus more intensively on his substance abuse problems.

Summary—This is a patient with chronic schizophrenia and a history of complaining about auditory hallucinations to avoid being discharged from hospital. When questions were raised about whether he was simulating auditory hallucinations and whether he needed to stay in hospital, he suddenly exhibited himself in a way that ensured he would be caught.

There are several possible reasons why this patient reported a worsening of his urges to exhibit when informed of his upcoming discharges. Anxiety about being discharged may have caused a true exacerbation of his disorders. Staff may have been more observant of the patient or spent more time listening to him during the discharge period. Or, he may have been intentionally trying to extend his hospital stay by demonstrating he was not "cured." However, the fact that he made certain that staff were aware of his "deterioration" suggests that his urges to exhibit were simulated in the same manner that his auditory hallucinations had been simulated to avoid being discharged.

Several other interesting aspects of this case that support the hypothesis that at least some of this patient's exhibitionistic "urges" and behaviors were simulated include the fact that he came from a family in which he had the opportunity to observe symptoms of both schizophrenia and exhibitionism in his family members. Patients who malinger or have factitious disorders will frequently imitate symptoms they have had the opportunity to observe. In addition, he had a past history of exacerbating schizophrenic symptoms (hallucinations) for the purpose of lengthening his hospital stay. His apparently intentional exhibitionism did not begin until after the validity of his hallucinations were questioned.

Results

The demographic and referral diagnoses at the time of admission for the three groups of patients are shown in Table 1. Patients who denied having any paraphilia tended to

TABLE 1—*Demographic and diagnostic characteristics of patients admitted to the JHSDU.*

	Confessors, $n = 13$	Deniers, $n = 3$	Simulators, $n = 4$
Mean age (SD)	30.8 (9.8)	47.0 (7.2)	33.3 (5.2)
Race (% white)	85	67	75
Years of school (SD)	12.7 (3.1)	12 (2)	13 (2.1)
Percent employed	30.8	67	25
Mean SES[a] (SD)	3.8 (0.8)	3.6 (0.5)	3.5 (1.3)
Percent self-referred	7.7	0	75
Percent legal charges	70	67	0
	PERCENT DIAGNOSES[b]		
Pedophilia			
heterosexual	23	100	0
homosexual	46	0	0
bisexual	0	0	0
Exhibitionism	8	0	50
Other	23	0	50

[a]Socioeconomic status as calculated using Hollingshead 2-factor method.
[b]Diagnostic category for which patient sought treatment or was referred.

be older and were more likely to be employed than patients in the other two groups. Not surprisingly, patients who denied having paraphilias were never self-referred. In contrast, 75% (three quarters) of the patients in the malingering group were self-referred. Approximately 70% of the patients in both the group that confessed to having a paraphilia and the group that denied having a paraphilia had legal charges current or pending at the time of admission to the JHSDU. However, none of the simulating patients was facing legal charges (although Case D had been charged for exhibitionism in the past). This difference is reflected in the fact that none of the Simulators chose to simulate pedophilia. Interestingly, three quarters of the simulators also met criteria for ego-dystonic homosexuality or bisexuality compared to only two sixteenths of the other patients. These same 3 patients also presented with a request to be treated with medroxyprogesterone (Cases B and C) or to have the dose they were taking increased (Case A).

Discussion

In a consecutive series of 20 patients admitted to a psychiatric unit specializing in the assessment and treatment of patients with paraphilias, 4 were found who appeared to have simulated at least some of the symptoms of the paraphilias for which they were admitted. To our knowledge, this is the first time this behavior has been reported in a patient group of this type.

Before discussing the implications of this study, several limitations imposed by the methodology of the study are important to acknowledge. The first and most important is the small sample size. The study was designed to be conducted over a specific time period during which only one of the authors (JPF) was attending to minimize possible differences in patient assessment that could occur with changes in attending physicians. While it is tempting to generalize from this group, we feel it is more proper to consider our initial findings preliminary and suitable only for descriptive analysis. The second shortcoming of this study is the fact that there is no truly objective measure of paraphilic fantasies. Although we have attempted to overcome this problem partially by using penile plethysmography, it is important to remember that this procedure is not a lie-detector test, and it is possible that we have been deceived by some of our patients. While this study does not permit any estimate of the true prevalence of simulated paraphilias, it

does suggest that estimates of the frequency of some sexual behaviors based on self-reports alone may be exaggerated.

Given these limitations, several implications are suggested by this study. In our experience it is quite unusual for sex offenders to refer themselves with the specific request that they be placed on medroxyprogesterone, and this did not occur with any of the 16 nonsimulating paraphilics in our sample. While it is only possible to speculate about the motivations for the behavior of the 4 simulators described, 2 recent social trends deserve consideration. The first is the AIDS epidemic that began in 1981. All 3 of the patients in the Simulator group with ego-dystonic homosexuality were terrified of the possibility of contracting AIDS. They all considered the possible loss of sexual interest caused by medroxyprogesterone to be a welcome side effect of treatment since it would decrease the likelihood that they would engage in what they considered to be potentially life-threatening male homosexual behaviors. Note that many of the patients in our group appeared to regard their paraphilias as easier to discuss and less embarrassing or distressing than their (nonparaphilic) homosexual orientation. It is possible that Cases A, B, and C were so uncomfortable with their homosexual or bisexual orientation that they sought medroxyprogesterone treatment to avoid acknowledging their sexual orientation directly. Fear of AIDS would certainly have made this more likely. If so, this represents an important new consideration in the assessment of patients who present to clinics that offer anti-androgen treatment.

The second important trend that has occurred recently is an increase in the legal requirements imposed upon clinicians to report sex offenders to the criminal justice system [*8,9*]. Cases A and C presented with complaints of paraphilias other than the ones they actually had. Case A was taken by surprise when his therapist of six years told him she was required to report him when he confessed his sexual activity with boys to her in what he thought was a confidential setting. After he learned that the JHSDU adhered to the same law he stopped talking about pedophilic interests altogether. Instead he complained of a nonreportable sex offense (zoophilia) when he felt his sex urges were becoming uncontrollable (and wanted admission to hospital). On the basis of this study we would hypothesize that the trend for patients to invent unusual or nonreportable paraphilias (Cases A, B, and C) is likely to become more frequent as laws requiring therapists to disclose confidential information become more common.

This study also suggests that while patients' self-reports about their sexual behaviors are absolutely necessary, they may not be sufficient for a complete assessment of paraphilias. In addition to the problem of paraphilic patients not reporting sexual behaviors, patients may also exaggerate reports or attempt to simulate paraphilic disorders that they do not have. This study also demonstrates the importance of not making assumptions about the sexual orientation of patients. Even on a specialty unit for sex offenders, patients may have difficulties acknowledging or admitting their homosexual orientation. It is unlikely we would have correctly diagnosed many of our patients if we had not specifically considered nonheterosexual sexual orientations as part of our routine assessment. Clinicians should be particularly careful when evaluating patients who complain of unusual or compulsive sexual behaviors or who request anti-androgens before a complete assessment of their sexual behaviors or fantasies has been completed.

In addition, although penile plethysmography is an expensive and specialized procedure, we feel it is an invaluable aid in helping patients become aware of their full range of sexual response patterns. The assessment phase in Cases A, B, and C was shortened considerably by using plethysmography to help the patients become aware of and discuss their sexual responses more honestly.

Finally, clinicians who specialize in the treatment of patients with sexual disorders should be aware that such clinics attract patients with a full range of psychopathology. There are several conditions which may mimic or complicate the paraphilias, including

mood disorders, schizophrenia, organic disorders and mental retardation, substance dependency syndromes, and medical illnesses. This study suggests that in addition to these, simulated disorders should also be considered.

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Erratum

In the article, "The Trial of Louis Riel: a Study in Canadian Psychiatry" (Vol. 37, No. 3, May 1992, p. 852), I erred in stating that Valentine Shortis was found not guilty of homicide, a verdict supported by the cabinet. In actuality, the insanity defense failed and Shortis was sentenced to death. The cabinet was evenly split over a recommendation for clemency. The Governor General, Lord Aberdeen, then commuted Shortis to "imprisonment for life as a *criminal lunatic* (italics mine), or otherwise as may be found fitting." This action exacerbated the discontent of French-Canadians over the Riel case. This decision in the Shortis case may have been a factor in the election of a Liberal, Wilfrid Laurier, who became the first French-Canadian prime minister of Canada in 1986.

Shortis remained incarcerated for 42 years; in the earlier years, he was frequently described as mentally ill. In his later years, he apparently functioned quite well and was released at age 62 in 1937; in 1941 he died suddenly of a heart attack.

Both the Jackson and Shortis cases reflect the fact that Canadian authorities were not adverse to considering the impact of mental illness in deciding the disposition of offenders, a step that was rejected in the Riel case.

I wish to thank Abraham L. Halpern, M.D., for bringing this error to my attention.

Irwin N. Perr, MD, JD

Erratum

The articles that appeared in the May issue of the journal under the Psychiatry and Behavioral Science Section Awards were erroneously labeled Case Reports on the title page.