

Cognitive–Behavioral Case Conceptualization for Assessment and Treatment of Necrophilia

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Introduction

Rare clinical disorders present unique challenges for practitioners, as there is a paucity of clinical research to provide guidance in treatment planning. Moreover, when practitioners are confronted with disorders that evoke a strong moral and/or emotional response, and are without an empirically supported treatment manual, personal beliefs and biases may strongly influence treatment decisions, such as the case with necrophilia. For practitioners, the why and how of an individual's problem often forms the basis for intervention. The dearth of treatment research on necrophilia has even led some to argue the best way to educate practitioners on necrophilia is by forming movie clubs to screen films that address necrophilic themes (Kalra, 2013). Frankly, this evidences the eclectic and seemingly desperate lengths some practitioners may go to in order to better understand this disorder. The goal of this chapter is to help the reader gain an understanding of case conceptualization for individuals with necrophilia—a case management and treatment planning skill. This will be accomplished by drawing connections between the nascent research on necrophilia and the relevant research on sexual violence,

deviancy, and sexual dysfunction in order to provide an empirically based cognitive-behavioral framework, as it has received extensive empirical support in the treatment of other paraphilias and sexual deviance (Beech & Harkins, 2012; Hanson, Bourgon, Helmus, & Hodgson, 2009; Marshall, Anderson, & Fernandez, 1999).

Definitional Issues

Clinical discussion of necrophilia began in 1865 with Krafft-Ebing's (1965) *Psychopathia Sexualis*, and described a disorder consisting of sexual behaviors with human remains, speculating the motivation may be sexual preference or psychosis. This minimal behavioral description seems to be one of the few points of definitional consensus. Like other rare paraphilic disorders, there is little consensus about the specific features of necrophilia. Since Krafft-Ebing, researchers have further subdivided necrophilia into different typologies. The most common division is between "true" and "pseudo" necrophilia (e.g., Rosman & Resnick, 1989) with the distinction being made by the degree of preferential arousal; variations on the theme of necrophilic fantasy have been discussed in psychodynamic literature (e.g., Lemma, 2013). There is necrophilia including contact sexual behaviors with human remains, and homicidal necrophilia, where an individual commits murder to obtain human remains. This typology, especially the concept of pseudonecrophilia, remains quite influential to this day (Bauer, Tatschner, & Patzelt, 2007; Stein, Schlesinger, & Pinizzotto, 2010).

Aggrawal (2009) observed the variability in use of "pseudonecrophilia" has diminished the clarity and utility of the term. In light of these inconsistencies, Aggrawal proposed a more comprehensive 10 stage classification system (see Aggrawal, 2011, for a detailed description). By clarifying numerous variations in presentation, Aggrawal's system facilitates a broad range of sexual behaviors linked with death and human remains (e.g., inclusion of non-deviant, noncriminal sexual role playing with necrophilic themes, necrophilia in the context of complex bereavement). The authors of

this chapter make few assumptions about the best typological framework for examining necrophilia. For the current purpose, we only presume the least contentious interpretation of necrophilia: sexual behavior with human remains. While simple, this definition reflects wording in most laws precluding sexual behaviors with human remains.

Prevalence and Presentation

The covert nature of necrophilia may allow many individuals to escape detection, explaining the absence of officially reported cases (Aggrawal, 2011; Smith & Dimock, 1983). Various studies have looked at necrophilia in sexual homicide offenders ranging from extremely low rates (0.3%; Häkkänen-Nyholm, Repo-Tiihonen, Lindberg, Salenius, & Weizmann-Henelius, 2008) to low (7.6%; Stein and colleagues, 2010) and 7.9%; Schlesinger, Kassen, Mesa, and Pinizzotto, 2010, respectively). Thus, a preliminary interpretation of the epidemiological evidence is necrophilia may covary with violence and deviance.

To the authors' awareness, Rosman and Resnick's 1989 study remains the largest empirical examination on necrophilia to date, with a total sample of 115 individuals based on international sample of case reports. Results provided important information on the mental health of the subjects. Psychosis and personality disorder diagnoses were made based on the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1987) with 17% ($n = 11$) of individuals having psychosis and 56% (32) having a personality disorder diagnosis. Of note, 64% of individuals in the sample had a history of sadistic behaviors. This finding is consistent with anecdotal evidence that necrophilia will likely be comorbid with other paraphilic disorders. Therefore, it stands to reason that the clinical presentation of these individuals will be complex, with multiple historic and current problems, which contribute to understanding the context and motivation for necrophilia.

Assessment

The purpose of assessment is to gain insight into the individual's problems in order to make recommendations for treatment and case management. In this section, brief guidance is provided on how to collect sufficient information in order to develop a case conceptualization. Specifically, information collected should pertain to describing the problem behavior, shedding light on the mechanisms maintaining this behavioral pattern, specific precipitants immediately preceding the behavior, and the origins of necrophilic behavior. Please note this guide for assessment is not exhaustive by any means and additional assessments, e.g., risk assessment, personality assessment, etc., may be useful. For a more detailed discussion of integrating risk and psychological variables in forensic case formulations, see Hart, Sturmey, Logan, and McMurrin (2011) or Sturmey and McMurrin (2011).

Client Management and Cognitive–Behavioral Case Conceptualization

Case conceptualization is a structured process to help practitioners understand the nature of the client's behavior by examining potential causal factors. Practitioners in the field of psychology use this process to tailor case management or treatment to the needs of the client. Ultimately, case conceptualization is a causal theory to identify treatment targets that will decrease risk for reoffending (Sturmey & McMurrin, 2011). Cognitive–behavioral therapy (CBT) is not a single manual, but a perspective on conducting psychotherapy rooted in a scientific approach to dealing with clinical problems (for a detailed description see Beck, 2011). By integrating cognitive, physiological, emotional, behavioral, and environmental elements together in a case conceptualization, practitioners can separate a problem into components and then hypothesize which aspects maintain the problem. Selecting treatment manuals or techniques that have undergone rigorous experimental testing increases the practitioners' confidence if changes in the targeted mechanism(s) do not equate with changes in the outcome measure, then the case conceptualization should be revised.

Persons (2008) presented four essential elements to case conceptualization used in the following discussion on treating individuals with necrophilia: (a) identify the problem—by conducting one or more semi-structured interviews with the client and a thorough assessment of all case file information. (b) hypothesize mechanisms (thoughts, feelings, behaviors, or physical sensations which functionally maintain the problematic behavior) that may be underlying necrophilic behavior for a client (c) pinpoint the proximal precipitants of the necrophilic behavior and (d) explore the distal origins of the necrophilic activity. For more on CBT case conceptualization, see Kuyken, Padesky, and Dudley (2011) or Persons (2008).

Identifying the Problem

Case formulation for complex clients should, at the very least, begin with a file review and interview(s) with the client. If possible, it is often also helpful to speak with individual close to the client (e.g., partners, family members, friends, work associates) to obtain an idea of this individual's psychosocial functioning. Indications of necrophilia will most often come from police reports, as clients are usually reticent to discuss deviant sexual fantasies (Harkins, Beech, & Goodwill, 2010). Based upon both the file review and interview(s) with the client, the practitioner will also want to evaluate, if appropriate, the presence of other paraphilias or other mental health concerns (Moscatello, 2010).

Engaging the Client. It is essential in establishing rapport the practitioner is educated and trained in forensic psychology and sexual behavior. Research evidences confrontational approaches to managing clients are more likely to evoke resistance and reduce change (Kear-Clowell & Pollack, 1997). Westwood, Wood, and Kemshall (2011) articulate the best practices for engaging with clients and promoting disclosure of information necessary to understand their case, e.g., during meetings with the client, practitioners should be warm and straightforward in their questioning style, and questions should be clear and open ended when possible to increase the opportunity for elaboration.

Risk Assessment. Once some level of comfort is experienced between the client and interviewer, it is recommended a semi-structured interview is conducted to score actuarial measures of static (e.g., STATIC-99R; Hanson & Thornton, 2000; Helmus, Thornton, Hanson, & Babchishin, 2012) and dynamic risk factors (e.g., STABLE-2007; Hanson, Harris, Scott, & Helmus, 2007;). Further interviews, such as the Hare Psychopathy Checklist–Revised (Hare, 1991, 2003) often provide a useful comprehensive framework to assess a wide variety of personality and behavioral variables relevant to individuals committing sexual violence, criminal history, and psychosocial functioning.

Crime Scene Analysis. For practitioners, primary sources of offense information can be obtained through interviews and a detailed review of file information (e.g., police reports). Table 29.1 identifies a list of crime scene variables that may be of use in defining the scope, extent, severity, and frequency of the problematic behaviors. At this initial stage, it is important to describe and define the offense behaviors. Ultimately, the best strategy is to provide a safe space for the client to talk about the offense. At first, try asking open-ended questions, for example, “Tell me what happened. I’m really curious to hear the details of your story,” often followed by prompts to go into more detail. Please refer to potential questions in the right-hand column of Table 29.1 to help collect information.

Table 29.1

Variable Description and Interview Guide for Crime Scene Analysis

[Insert Table 29.1 here]

After collecting evidence, the second stage of a crime scene analysis (CSA) is to identify necessary and sufficient elements of the offense. The output of such a decision-making process should

be variables useful to construct a narrative about what happened during the offense; at this time, there is no empirically supported method to prune the variables collected. Moreover, the client may advertently or inadvertently tell untruths, distort behavior, and minimize (or maximize) aspects of their crimes in constructing a narrative to their crime(s).

Psychopathology. Individuals committing necrophilic acts are often diagnosed with other specified paraphilic disorder (necrophilia) using the DSM-5 (American Psychiatric Association, 2013). However, it is important to understand the presence of sexual behavior with human remains is not sufficient for a diagnosis. There has to be evidence this act represents a sexual preoccupation with human remains that has been present for a prolonged period of time (e.g., 6 months in DSM-5). Individuals with necrophilia are likely to have other comorbid paraphilias such as sexual arousal to drinking blood (Jaffe & Dicataldo, 1994), zoophilia, urophilia, or coprophilia (Aggrawal, 2011). Sexual sadism may also be indicated in cases where the individual was sexually aroused by pre- or postmortem acts to torture or humiliate the victim. A thorough assessment of the individual's sexual behaviors and history will elucidate many issues concerning the presence of multiple paraphilia, for additional information refer to Hanson & Harris, 2000, or Hanson & Morton-Bourgon, 2009. The practitioner should consider if it is possible to obtain responses on the Multiphasic Sex Inventory (MSI; Nichols & Molinder, 1984), a brief and comprehensive self-report measure that produces 20 scales on paraphilias, sexual dysfunction, sexual knowledge, and treatment attitudes. Penile plethysmograph or phallometric assessments are useful physiological measures of deviant sexual arousal (Freund & Blanchard, 1989; Marshall & Fernandez, 2000). Measuring arousal to sexual violence may provide support for different mechanisms in the case conceptualization.

Whether the client has had significant issues with mental illness should also be explored. In particular, as mentioned previously, psychotic and personality disorders are often overrepresented

among individuals who engage in necrophilia (Rosman & Resnick, 1989). Substance use was also evidenced in Rosman and Resnick's sample as proximal behaviors to the offense. This is consistent with other findings of high rates of substance use, and other mental disorders, in other cases of necrophilia (Moscatello, 2010) and among samples of individuals committing sexual violence (Leue, Borchard, & Hoyer, 2004; Looman, Abracen, DiFazio, & Maillet, 2004). Given the potential diagnostic complexity of these cases, standardized structured assessment tools, like the Structured Clinical Interview for DSM IV-TR disorder (First, Spitzer, Gibbon, & Williams, 1996) or the Mini Neuropsychiatric Interview (Sheehan et al., 1997), should be used to ensure reliable diagnostic information is collected.

Mechanisms

Mechanisms are cognitions, behaviors, emotional processes, physical experiences, or environmental factors that have a causal relationship to the problem of interest. Information collected in the assessment will be useful to forming a hypothesis about mechanisms as to why the behavior occurred. Based upon a review of existing clinical literature, three clusters of mechanisms are proposed: (a) sexual arousal, (b) sexual sadism, and (c) intimacy aversion. These mechanisms are not exhaustive of the possible explanations of why individuals engage in necrophilia and practitioners should use the following approach as a guide to examine alternative hypotheses, which may reveal the function of the behavior was not necrophilic.

Sexual Arousal Hypothesis. The most assumed mechanistic hypothesis is the client experiences deviant sexual fantasies and physiological arousal to human remains. Behavioral explanations are often the easiest to speculate with paraphilia specifically, the pairing of sexual arousal and orgasm with human remains increases the likelihood future human remains or death-related stimuli will trigger sexual arousal, increasing the likelihood for the individual to engage in that behavior. This behavioral could be expanded using theories of sexual aggression like Hall and Hirschman's (1991)

quadripartite model, in which they argued that the etiology of sexual violence could be reduced to four essential factors: physiological arousal, emotion dysregulation, cognitions supporting sexual violence, and personality problems. Examining the impact of other propensities (e.g., cognitive distortions) may have incremental value as they further explain how clients are able to overcome aversive sensory elements present in human remains to gain sexual satisfaction. Rosman and Resnick (1989) only found that 15% of their sample of 122 cases of necrophilia reported conscious sexual attraction to human remains. Therefore, while knowledge of the sexual arousal mechanism is important to proceeding with treatment in at a subsection of this population, it does not explain the cause of most client's behavior.

Sexual Sadism Hypothesis. For some individuals, sexual acts with human remains are arousing due to the power they have to humiliate and degrade the victim. Sadism is not just motivated by violence, but it is also motivated by the perceived ability to humiliate and degrade the victim. Therefore, in conceptualizing a case as involving sexual sadism, it is important to verify the client experienced sexual arousal by perceiving his sexual acts as violating and fouling the human remains. In cases such as these, the motivations are likely indicative of broader issues with sexual sadism. Diagnosing sadism is a difficult and unreliable process (Kingston & Yates, 2008) thus inquiring about the client's pornography use and sexual encounters for evidence of violent themes may prove useful. Given the similar moral reprehensibility of necrophilia and sadism, practitioners should not assume one is indicative of the other (Moll, 1926).

Intimacy Aversion Hypothesis. The intimacy aversion hypothesis is a novel explanation of necrophilia positing sexual activity with human remains is a result of severe anticipation and intolerance of receiving ridicule and rejection from a conscious partner. This mechanism likely explains the most common motivation to engage in necrophilia (68%) in Rosman and Resnick's (1989) sample. Other

similar motivations in their study were attempt to gain comfort, overcome feelings of isolation, unavailability of a living partner, and a compensation for a fear of women.

Intimacy aversion is hypothesized to be an extreme form of intimacy deficits present in general sex offenders. Need for intimacy is more than an empirically supported risk factor, it contributes to a psychologically meaningful explanation for the cause of sexual violence (Mann, Hanson, & Thornton, 2010). Marshall (1989) argued sexual violence results from deficits in intimacy and social functioning limiting individuals' abilities to engage with consenting sexual partners, producing loneliness. This theoretical move built upon previous research on intimacy in the adult and child attachment literature (for a summary, see Marshall, Bryce, Hudson, Ward, & Moth, 1996, or Marshall & Marshall, 2010). Attachment describes the nature of one's social competence and views of their own interpersonal relationship often contrasted as secure and various insecure styles (Bowlby, 1969, 1973). Adults are said to demonstrate insecure attachment if, as a result of their developmental experiences, they experience difficulty forming and maintaining close relationships with others and experience emotional loneliness as a result. It is an extreme form of this insecure attachment style that may characterize clients who are so averse to sexual contact with conscious partners that they are compelled to engage in sexual acts with human remains. For an in-depth review of theories of intimacy, please see in Ward, Polaschek, and Beech (2006).

Evidence from CSA, such as positioning, role-play, or engaging in pseudo-intimate acts, may indicate a pattern of intimacy deficits. These behaviors contribute to a narrative of the offense that has the client seeking out sexual partners who are incapable of rejecting them (i.e., human remains). These individuals may also report the absence of stable relationships further evidencing a pervasive problem with establishing emotional intimacy and engaging in healthy sexual activities with another consenting partner (excluding erotic dancers or sex workers). Segal (1953) and Lazarus (1968) give detailed accounts

of individuals coping with necrophilic fantasies likely based in aversion to intimacy with a responsive partner.

Proximal Precipitants

Precipitant and origins provide information about events that triggered the necrophilic behavior. Origins provide insight as to the beginning of problem behavior by identifying the learning experiences that developed the initial causal mechanisms. Precipitants are critical events that triggered a chain reaction of thoughts, feelings, physical sensations, and behaviors that led to the necrophilic act. An analogy could be made to the diathesis-stress model of disorders (Persons, 2008). The mechanism is the diathesis, predisposing someone to engaging in necrophilic behaviors. The origin is the beginning of that mechanism/diathesis. The precipitant is the stressor that activated the elements of the mechanism/diathesis. Identifying the steps between the precipitant and the offense provide a series of treatment targets on which to intervene.

Triggers and Destabilizers. Often, precipitants are not immediately evident after reviewing a case. Sometimes, it was not one but a series of events accumulated over days, weeks, or even months to lead the individual to engage in the behavior. Unsurprisingly, the client will, even if highly motivated, be a poor historian on these events. A good question to ask when sifting through potential precipitant candidates is “What was the thing that happened that sent this person on the path to the problem behavior”? When discussing precipitants with clients, it may become apparent that, had the precipitant not occurred, it is doubtful that the person would have engaged in the problem behavior at that time.

Identifying Distal Origin(s). It is hypothesized the mechanism developed from a single or series of events interacting with an underlying genetic predisposition(s). For instance, in a case study on necrophilia, Boureghda, Betz, Philipp-Wiegmann, and Rosler (2011) reported the client vividly remembered seeing his father kill and slaughter hares and rabbits. He said those memories always

stayed with him and he became preoccupied with death. The impact of these experiences are recursive, as clients' deficits or propensities worsen are more likely to rely on maladaptive coping strategies deepen the problem. The process of identifying origins can be immeasurably more challenging than identifying precipitants. A potentially fruitful path of inquiry is exploring trauma history, especially concerning sexual assault. Individuals who engage in deviant sexual behavior are more likely than other offenders to have a history of violence and sexual abuse (Levenson & Socia, 2015). From a cognitive perspective, traumatic events can be a potent influence on mental health if the individual alters his beliefs and values to make sense of the trauma. Using cognitive theory, practitioners may uncover distorted patterns in thinking related to necrophilia. By following the history of these beliefs, practitioners are likely to identify origins.

Treatment

Current efforts to identify effective means to treat sexual offenders arose in response to early conclusions that "nothing works" to reduce reoffending (Martinson, 1974). Recent meta-analytic findings show psychological interventions can substantially lower rates for reoffending when they follow the risk-need-responsivity (RNR) model of effective offender management (Andrews & Bonta, 1998; Hanson, Bourgon, Helmus, & Hodgson, 2009; Hanson & Yates, 2013). The *risk* principles state the amount of services individuals receive should be consistent with their likelihood to reoffend. The *needs* principle states treatment programs will be most effective in reducing reoffending when they target factors empirically linked to risk for reoffending. Lastly, *responsivity* refers to the process of treatment in which the client is able to benefit. This may require addressing potentially non-criminogenic issues interfering with treatment success, such as motivation and learning styles (see Marshall et al., 1999; Marshall, Marshall, Serran, & O'Brien, 2011; Stinson & Becker, 2013 for additional information). Abracen and Looman proposed an integrated model of sexual offending including issues associated with both

dynamic (i.e., changeable) risk factors as well as a history of trauma and serious mental illness (Abracen & Looman, in press; Looman & Abracen, 2013). This work builds upon Marshall's theory of intimacy deficits in sexual offending and the RNR model and offers an empirically supported model in the management of high-risk high-need sexual offenders.

Specific Treatment Strategies

Common targets in comprehensive treatment program include attitudes and cognitions about sexuality, emotion regulation, relationship problems, and sexual deviance (Beech & Ward, 2004; Marshall et al., 2011). The three mechanism hypotheses presented previously parallel common treatment targets: managing sexual deviance or addressing interpersonal deficits. When case conceptualization identifies sexual arousal or sexual sadism as a cause of necrophilia, then the goal of treatment is to bring the deviant sexual arousal under control through behavioral and cognitive interventions. Marshall, O'Brien, and Marshall (2009) provide detailed descriptions of behavioral methods to modify sexual preferences. These methods are based upon behavioral principles of respondent and operant conditioning and divided into aversive therapies and masturbation reconditioning. However, strictly focusing on modifying deviant sexual arousal constitutes an incomplete treatment program (Marshall, 1971) as modern treatment approaches include multifaceted treatment targets. Moreover, there is still a lack of consensus concerning the effectiveness of these methods in changing deviant sexual arousal (Seto, 2008).

Addressing concerns with sexuality, practitioners should not focus on deviance to the exclusion of issues with sexual preoccupation and promoting healthy sexuality. Sexual preoccupation refers to a tendency in individuals to use sexuality as a means to regulate negative affect (Cortoni & Marshall, 2001). Intervening for these individuals requires providing skills to tolerate negative emotions, regulate mood, and promote enjoyable leisure activities. Considering sexuality on a continuum of health-deviant

behaviors will increase flexibility in their thinking (Marshall et al., 2011). There are a number of treatment programs of sexual offenders focusing on healthy sexuality (O'Brien, 2004; Sinclair, 2009).

Contrarily, a noteworthy clinical ramification of the intimacy aversion hypothesis is human remains may not sexually arouse clients, they just simply may not be averse to use human remains for sexual activity. This critical distinction is important in making effective treatment recommendations. Treatment planning based on a conceptualization the client is intimacy averse could include a host of cognitive-behavioral interventions and social skills focused on interpersonal functioning. After educating clients on the aspects of attachment discussed previously, it is important to have clients examine their beliefs and attitudes toward sexual relations. Distortions are likely to arise regarding role expectations and the relationship between sexual, emotional, and social satisfaction with intimate partners. Jealousy may be an important issue for clients, especially those motivated to completely control their partner. Relationship skills should build upon a larger general social skills program clients should receive, especially if they demonstrate a high degree of instability in interpersonal relationships. Specific skills training should include attention to who is an appropriate partner, effective communication, and conflict resolution. At this point, expectations should be examined and explored for unrealistic beliefs about roles in the relationship. Lastly, intervening on loneliness is worth noting as it is part of the case narrative. As loneliness is not an empirically supported risk factor (Mann et al., 2010), providing social support and emotion regulation skills should be directly connected to risk-relevant treatment targets.

Discussion

Necrophilia is a rare problem that invokes intense emotional reactions from both the community and forensic professionals potentially, leaving practitioners thinking clients are unmanageable. By clearly articulating the problem(s) for which the client is referred for treatment,

hypothesizing the thoughts, feelings, behaviors, or physical sensations that maintain and perpetuate the problem (mechanisms), and isolating the triggers and origins of this problem, a practitioner has constructed a thorough case conceptualization to guide treatment and management of an individual with necrophilia. A conceptualization is dynamic, and sensitive to change with new information. This flexibility is crucial to effective client management as harm can be done when a practitioner's rigid adherence to a conceptualization may blind them to more fruitful paths of intervention.

The current treatment framework is understandably limited based upon the theoretical and empirical evidence of necrophilia. A specific limitation of the current framework is it does not conceptualize individuals who engage in types of pseudonecrophilic behavior, such as consenting sexual acts between conscious adults pretending to be dead (role players) and bereaved individuals (romantic necrophiles; Aggrawal, 2009).

There is some precedent supporting practitioners who wish to address necrophilia from a non-CBT perspective. Although one case study has been published using behavioral principles to treat a client with necrophilic fantasies (Lazarus, 1968), many other treatment cases have been published using hypnotherapeutic (Ehrenreich, 1960) and psychodynamic (Segal, 1953) methods. Regardless of theoretical orientation, it is important the interventions selected have a theoretical *and* empirical basis for reducing the risk of the client engaging in further necrophilic behaviors.

The mechanisms for necrophilia have far-reaching etiological explanations and causes best understood through an integrated model of sexual behavior. The present chapter is the first attempt to synthesize exigent research on necrophilia with our current understanding of best practices for managing individuals who commit sexual violence. Like case conceptualization, management of these clients will evolve as practitioners explore and evaluate the steps outlined previously. By beginning to

coordinate efforts in management these individuals, it is hoped future research will be able to analyze treatment findings to further elucidate best management strategies for this extraordinary paraphilia.

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