The Role of Psychiatry in Sex Offender Management

By H. Martin Malin, PhD [6] and Fabian M. Saleh, MD [7]

Medicine and law have a rich collaborative history in the management of persons convicted of sex offenses. Despite different assumptions about the offender and different perspectives about management and goals that may only partly overlap, each discipline offers significant expertise that promotes healing and risk management strategies while increasing community safety.

The term “sex offender” is a legal, not a psychiatric, designation. Sex offenders make up a psychiatrically heterogeneous group of individuals whose only unifying characteristic is that they have violated the law governing sexual expression in a given culture. The law may not greatly concern itself with the biopsychosocial antecedents of illegal sexual behavior, although it recognizes that questions of intent and incompetence or diminished capacity are important considerations.

Psychiatrists, like all physicians, view sexual behavior in terms of health. Normal sexual behavior is roughly equated with healthy sexual behavior; abnormal sexual behavior invites psychiatric intervention to restore a patient’s sexual health.

In our experience, psychiatrists infer the presence of a sexual disorder or abnormality from certain statistically rare sexual behaviors and/or self-reported distress. Like all physicians, psychiatrists then arrive at a diagnosis congruent with the clinical picture. Differential diagnosis is important because identical behaviors or symptoms often have very different etiologies. Diagnosis typically informs the psychiatrist’s choice of therapies intended to diminish or control the patient’s sexually abnormal behavior.

Psychiatrists tend to believe that factors that motivate sexual behavior are intrinsic to the organism. Such intrinsic factors might include psychosis, PTSD, and abnormal biological drive states and, therefore, are more constant across history than the ethical and philosophical underpinnings of a culture as expressed in its laws. The legal construct of a “sex offense,” is more tightly culture-bound. Social attitudes toward sexual behaviors are not immutable, however, and laws change, both reflecting and reshaping cultural values.

For example, in the past 50 years, society and psychiatry have radically changed perspective and judgment of homosexuality. Before the 1970s, most of the psychiatric community viewed homosexuality as a mental disorder, a concept enshrined in DSM in 1952. In this first DSM, homosexuality was categorized as a “sexual deviation” presumed to be a “personality disorder of psychogenic origin or without clearly defined tangible cause or structural change.” In 1973, the American Psychiatric Association eliminated homosexuality as a mental disorder in the sixth printing of DSM-II, substituting a new category, Sexual Orientation Disturbance. Laws about homosexuality also reflect changing psychiatric and social attitudes. Legally, same sex behavior could be lawful in one state and criminalized in another. For example, in 1986, the US
Supreme Court affirmed the illegality of engaging in homosexual behavior in Georgia that was not illegal in other states, declaring that “to hold that the act of homosexual sodomy is somehow protected as a fundamental right would be to cast aside millennia of moral teaching.” Thus, Georgians engaging in sodomy were officially “sex offenders” while residents of many other states who engaged in sodomy were not. Less than 2 decades later, however, the Court reversed itself, declaring that laws prohibiting sodomy between consenting adults, in the 14 states that still had them, were unconstitutional.

In the past year, 2 of those states (Montana and Virginia) have repealed their anti-sodomy statutes, but in 12 other states (Alabama, Florida, Idaho, Kansas, Louisiana, Michigan, Mississippi, North Carolina, Oklahoma, South Carolina, Texas, and Utah), engaging in consensual sodomy (ie, oral and/or anal sexual activity) continues to make one a sex offender.

**Underlying factors and prevention**

Psychiatric and legal professionals agree that some sex offenders can be dangerous to society. Both professions are invested in preventing dangerous sex offenders from doing harm to others and to the social order. From the legal perspective, harm prevention generally means removing offenders from free society through incarceration or involuntary detention. Under the law, there are 5 commonly accepted goals of incarceration: incapacitation, punishment, rehabilitation, deterrence, and restitutio. More recently, in the era of sexually violent predator statutes, isolation from the culture at large may continue following incarceration by stigmatizing the offender with the lifelong designation of registered sex offender and possible indefinite civil commitment for treatment.

The perspective is somewhat different for psychiatrists, particularly those who do not consider themselves to be forensic specialists. Without denying that sex offenders have committed crimes, some psychiatrists may see the individual offender as a patient first and an offender second. The physician-patient relationship includes a fiduciary duty to ameliorate the patient’s pain and suffering and restore him or her to healthier psychosocial functioning. For some psychiatrists, this duty clashes with such legal requirements as reporting mandates.

The psychiatrist's understanding of sexual behavior, legal or illegal, is that sexual activity takes place in the context of arousal mediated by a biologically based drive. Disordered arousal and behavior are the legitimate focus of psychiatric intervention. Psychiatrists also know that disordered sexual behavior is a feature of a number of psychiatric conditions other than arousal disorders.

Berlin and colleagues reported on a series of 6 case examples of rape with disparate motivation: a sociopathic, opportunistic rapist; an “angry” rapist; a developmentally impaired rapist; a psychotic rapist; a sexually driven rapist; and sexual assault by a voyeuristic rapist (a rare case). Rape is clearly criminal behavior. Thus, all of Berlin and associates’ patients were sex offenders. Psychiatry would perceive these patients’ criminal conduct as having very different causes. Treatment would also vary. Courts and prisons would attend to victim harm, mitigating factors, treatment efficacy, rehabilitative potential, and future risk to society to determine the prisoner’s condition and duration of confinement.

Psychiatrists also know that some criminalized sexual behaviors are not directly related to mental disorders. Exposing one’s genitals to unsuspecting victims, for example, may be a focus of both legal and psychiatric concern in the context of paraphilic exhibitionism, traumatic brain injury, or command auditory hallucinations. While “streaking” at a football game or public urination may be construed as indecent exposure and, therefore, sex offenses, psychiatrists are unlikely to see these behaviors as mentally disordered.

Psychiatrists can often assist both the patient and the legal system by providing information about the differential diagnosis applicable to a particular sex offender and the likelihood that psychiatric treatment might lower the risk of recidivism and, therefore, future harm to society. It is important to determine whether an offender has a paraphilic disorder related to his sex offense because the hallmark of the paraphilias is recurring, intense sexually arousing fantasies, urges, or behaviors. This raises issues of volition and competence to conform behaviors to expected norms. Unless they are in legal jeopardy, patients with paraphilias rarely seek professional help because of the associated stigma and shame. As Berlin and colleagues point out, mandatory reporting laws for certain sexual crimes may also reduce the number of patients who seek voluntary treatment.

**Treatment strategies**

Intellectual disabilities, pervasive developmental disorders, ADHD, conduct disorder, personality disorders, psychotic disorders, mood disorders, anxiety disorders, and (especially) substance use disorders are sometimes diagnosed concurrently in sex offenders. Any of these comorbid conditions may require treatment in addition to sex offender–specific treatment, since they may actually be
precipitating or maintaining the illegal sexual behaviors. Even if the comorbid disorder has little or nothing to do with the sexual offense, it must be managed so it does not interfere with the intense regimen of sex offender–specific treatment.  

Treatment of comorbid conditions associated with sex offending is generally bimodal, employing both biological and psychosocial interventions. The goal is to eliminate sexually abusive fantasies and work toward more healthy sexual expression, although it is not easy to manage the harmful while concurrently nurturing the helpful in treating potentially dangerous sexual patterns such as pedophilia.  

Dunsieth suggested a multidisciplinary model employing a cognitive approach to relapse prevention; substance use treatment; and an assessment for major mental illnesses, including paraphilias. Evidence-based integrated treatment approaches—eg, the Good Lives Model—use directive cognitive-behavioral therapy with instruction in appropriate expression and regulation of emotions to help patients build self-esteem, learn how to take responsibility for behaviors, identify the pathways to offending, control deviant sexual interests, and develop coping and mood-management skills.  

Effective psychological methods include strategies for prevention as well as psychoeducation and skills-building typically based on social learning, behavioral/cognitive-behavioral, and sometimes psychodynamic theories. Techniques include olfactory aversion conditioning, covert sensitization, masturbatory satiation, and masturbatory reconditioning. Regardless of the method, the goal is to decrease problematic sexual arousal and cultivate appropriate sexual response patterns. Pharmacological methods focus on reducing, and in some cases eliminating, sex drive and associated cravings, and thoughts and fantasies that can become so intense and/or overpowering that a medication is needed to dampen the drive sufficiently to allow for learning; other management techniques may also be used. Medications are used to treat the primary and comorbid disorders.  

Antiandrogens, antagonadotropics, and other hormonal agents as well as SSRIs may, in carefully selected cases, diminish sexual interest and associated thoughts and fantasies. SSRIs are latecomers to the pharmaceutical arsenal for managing sex drive and intrusive fantasies and are less well studied than medications that act directly to reduce sex hormones. Rösl er and Witzum determined that more rigorous study is needed before concluding that SSRIs are effective for treating paraphilic symptoms. SSRIs may be appropriate for compulsive sexual behaviors but should not be relied on exclusively in the treatment of sexual sadism or pedophilia because of the dangerousness of these paraphilias.  

Other medications include antipsychotics (eg, thioridazine, fluphenazine, haloperidol), mood stabilizers (eg, lithium, topiramate, car-bamazepine), and other agents (eg, desipramine, imipramine, clomipramine, buspirone, naltrexone). These medications are used for the treatment of comorbid psychiatric disorders rather than the primary sexual disorder. Treatment of sex offenders should be considered a means to manage rather than cure sexual offending behavior and thus reduce sexual recidivism risk. There is certainly some evidence that re-offending behaviors can be reduced for some offenders, but there is not a large literature base of rigorous studies and the behavior is difficult to study accurately. Despite the considerable differences in perspective, both psychiatry and the law continue to inform each other’s understanding of treatment and management strategies where sex offenders are concerned. Both disciplines require further scholarly inquiry to inform decisions about recidivism, risk management, and community safety.  

Disclosures:  

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