PSYCHIATRIC TREATMENT OF SEXUAL OFFENDERS

Publication Number 1104
AMERICAN SERIES
IN
BEHAVIORAL SCIENCE AND LAW

Edited by
RALPH SLOVENKO, B.E., LL.B., M.A., Ph.D.
Professor of Law and Psychiatry
Wayne State University
Law School
Detroit, Michigan

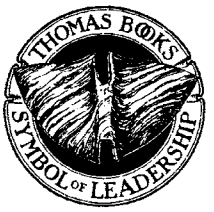
PSYCHIATRIC TREATMENT OF SEXUAL OFFENDERS

Treating the Past Traumas in Traumatizers

A Bio-Psycho-Social Perspective

Edited by

JAMSHID A. MARVASTI, M.D.



CHARLES C THOMAS • PUBLISHER, LTD.
Springfield • Illinois • U.S.A.

Published and Distributed Throughout the World by

CHARLES C THOMAS • PUBLISHER, LTD.
2600 South First Street
Springfield, Illinois 62704

ISBN 0-398-07454-2 (hard)
ISBN 0-398-07455-0 (paper)

Library of Congress Catalog Card Number: 2003060735

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Printed in the United States of America
SM-R-3

Library of Congress Cataloging-in-Publication Data

Psychiatric treatment of sexual offenders : treating the past traumas in traumatizers ; a bio-psycho-social perspective / edited by Jamshid A. Marvasti.
p. cm. -- (American series in behavioral science and law)
ISBN 0-398-07454-2 -- ISBN 0-398-07455-0 (pbk.)
1. Sex offenders--Mental health. 2. Sex offenders--Rehabilitation. 3. Psychosexual disorders--Treatment. I. Marvasti, Jamshid A. II. Series.

RC560.S47P794 2003
616.85'83--dc22

2003060735

This book is dedicated to New England Clinical Associates, to it's Executive Director Suzanne M. Sgroi, M.D., for being "the wind beneath my wings," to its clients (sexual offenders of children) who not only have allowed me to see the tender and humanistic sides of them,

but also

who have helped me to discover the frightened, abandoned, and abused "little child" within them,

and

who have permitted me to hold, comfort, and shelter their inner "little child," in my arms. . . .

CONTRIBUTORS

Donald G. Sukosky, Ph.D. is Professor of Sociology at the University of Hartford where he teaches courses on Marriage and Family, Adult Development, and Social Gerontology. Dr. Sukosky is a licensed Marriage and Family Therapist and holds Diplomat and Clinical status at the American College of Counselors. Dr. Sukosky holds degrees from Trinity College, Mt. Airy Seminary, Philadelphia, Harvard University, and the Hartford Seminary Foundation. Sukosky's articles have been published in a number of professional journals.

Karen M. Colt, M.Ed. is a clinician at Manchester Memorial Hospital (Manchester, Connecticut) where she works with inpatient and outpatient psychiatric and dual diagnosis populations. Ms. Colt earned a Master of Education in Counseling Psychology from Cambridge College and is an honor graduate of the Drug and Alcohol Rehabilitation Counseling Program at Manchester Community Technical College (Manchester, Connecticut).

FOREWORD

One of the main attractions at an annual meeting of the American College of Forensic Psychiatry was the presentation on sex offenders by Dr. Jamshid A. Marvasti. Afterwards, I expressed the hope to Dr. Marvasti that he do a book on the subject for the American Series in Behavioral Science and Law. I am delighted that he agreed. He worked prodigiously on it, and this book, *Psychiatric Treatment of Sexual Offenders,* is the outcome. It is a welcome and valuable contribution to the literature.

The book consists of eight chapters. Chapter 1 discusses paraphilias and sex offense behavior. Chapter 2 focuses on the typology and characteristics of pedophiles and rapists. Chapters 3 and 4 discuss the issues of sex offense and treatment of paraphiliacs and child molesters. Chapter 5 focuses on cognitive behavioral therapy, risk assessment, and relapse prevention for sex offenders. Chapter 6 discusses pharmacotherapy and surgical castration of paraphiliacs and sex offenders. Chapter 7 discusses the biopsychosocial factors that may influence a victim of abuse to become a perpetrator of abuse. Chapter 8, the final chapter, discusses behavioral responses that may follow exposure to trauma. Donald G. Sukosky, Ph.D., joined Dr. Marvasti in the preparation of Chapter 3 and Karen M. Colt, M.Ed., joined Dr. Marvasti on Chapters 7 and 8.

The position of this book is that any sex offender who has a history of childhood trauma needs to be treated not only for the sex offenses, but also for past trauma. Incest and child sexual abuse is a widespread problem that has gained the attention of increasing numbers of law enforcement, judicial, and mental health officials. As a result of the concern, traditional legal rules have been modified to facilitate the prosecution of these offenders. In a departure from long-established doctrine, the rules of evidence have been amended to allow evidence

of other acts of sexual assault to establish propensity to commit another sexual assault. Various jurisdictions have enacted legislation extending the statute of limitations in child sexual abuse cases. Several jurisdictions have extended the statute of limitations in such cases to allow victims of any age to sue within three years after they "discover" the cause of their disability, no matter how old they are.

Of course, such cases raise the question of causality. In a case in Los Angeles, for example, the parents of a deeply depressed man said that as a youth he was sexually molested by a Roman Catholic lay brother. They sued the Los Angeles Archdiocese for damages resulting from their son's suicide, at age 36. The lawsuit noted that the individual sought professional counseling for years, and that he kept a diary that detailed his pain and suffering resulting from the abuse (C. Sims, "Suit Says Abuse by Friar Led to Son's Suicide," *New York Times,* April 19, 2003, p. 9). Yet the calculation of action and reaction in a human being is not at all like that in physics. In the working of the brain, multiple variables continually interact to produce an action or reaction.

The statistics of the U.S. Department of Justice point out that nearly nine out of ten rapes or sexual assault victimizations involved a single offender with whom the victim had a previous relationship, such as a family member, intimate, or acquaintance. In many other countries, sexual assault by strangers is more common, as in South Africa which has the highest rate of rape in the world. Rape of young girls who are virgin occur with some frequency. As Dr. Marvasti notes, there is the belief that having sex with a virgin may cure HIV infection. Because of the enormity of the number of rapes, special rape courts have been set up in South Africa. Vigilantism is rife.

It is common knowledge that sex mores vary in every culture, and indeed, between different social strata in the same locality. Freud tells us in his essay *Taboo of Virginity* of the *jus primae noctis* (right of the first night) of medieval feudal lords. In Japan public kissing is taboo, while the nude bathing of men and women is acceptable. In the pagan civilization of the Greeks, the love of boys was famous, and the Romans could enjoy official taxed male prostitutes. On the other hand, Leviticus XX, 13, declared, "If a man lie with mankind, as with womankind, both of them have committed abomination; they shall surely be put to death; their blood shall be upon them." We have no means of discovering how often, if at all, the penalty was inflicted.

Subsequent authorities quoted in the penitentials noted the imposition of heavier penances for clerics than for laymen, for mature men than for youths, and many made the distinction between habitual and occasional offenders and several attempted even to distinguish between the varying degrees of physical contact involved. Nowadays, in media reports of sexual abuse, the nature of it is not specified, whether it was sodomy, masturbation, or fondling, or whether it was coerced or consequential, as though the difference were inconsequential.

In a book published in 2000, *Child Suffering in the World,* Dr. Marvasti as editor chronicled the suffering of children in every hemisphere and on every continent. Each chapter described the plight of populations or subpopulations of children in a different culture. Dr. Marvasti labored for six years to compile those accounts. The book at hand takes the position that sexual trauma in some children and adolescents may lead to physical and psychological disorders, though it is recognized that not every sexually abused child is damaged or harmed, and not every child sexual encounter is a trauma that will result in a psychiatric disorder.

Dr. Marvasti was born and raised in Iran, and was trained in the United States as a child and adult psychiatrist and where he has practiced for some 30 years. He resides in Manchester, Connecticut. His colleagues describe him as a tireless advocate who has helped countless children whom he has evaluated and treated, often for reduced remuneration or no fee at all. His particular professional interest has been in learning better ways to recognize and treat sexual trauma in children and adults and to help prevent child sexual abuse by treating abusers and families as well as victims.

Ralph Slovenko, Editor
American Series
in
Behavioral Science and Law

PREFACE

The concept of this book evolved after I had presented a scientific paper at the annual meeting of the American College of Forensic Psychiatry in Toronto (Marvasti, 2001). Shortly thereafter, a member of the audience, Professor Ralph Slovenko, sent me a letter asking me if I would be interested in writing a book on the subject that I had addressed at the conference. The suggestion appealed to me for a number of reasons. First, I have been studying the neurobiological aspects of victims/offenders of sexual aggression for the past 25 years. During this period, I have evaluated and treated individuals of both groups in an outpatient setting, partial hospitalization program, inpatient psychiatric hospital, and in nursing homes (e.g., for elderly sexual offenders with dementia). For some time, I have had a desire to integrate these clinical experiences with research findings regarding the neurobiological abnormalities associated with child maltreatment, stresses, and emotional traumas.

Second, during the course of my practice, I have had the opportunity to witness the process of change from a punitive/criminal approach to one emphasizing clinical intervention for sexual offenders of children. In popular phraseology, the public's attitude has changed from "lock 'em up forever" and "castrate them permanently" to "these people are also human beings; and "someone did the same things to them in their childhood." Put in simple terms, the concept of the "dirty old man" has shifted to the "sick, demented man," and paraphilia has become a medical diagnosis. With this gradual shift in public opinion, the health industry also has come to recognize such disorders as public health problems, rather than moral issues exclusively. As a result, institutions such as prison systems and insurance companies include provisions for the treatment of child molesters whose symptoms meet the criteria for the paraphilia diagnosis.

In reality, vacillation between these two poles of criminal versus clinical intervention is more apparent than any direct movement from one pole to the other. Overall, though, substantial change regarding the issue of sexual offenders has occurred, so it seemed appropriate to inspire further progress through publication at this time.

The approach of this book is a humanistic one that characterizes the individual suffering from paraphilia as a human being, a patient who may not have any choice in determining his or her sexual orientation. It is possible that the quality and quantity (intensity) of one's sexuality is predetermined, and not open to selection. Two chapters of this book focus on offenders who are also victims, having been sexually/physically/emotionally traumatized in their pasts, especially during their years of development. Recent research points to the possibility that negative events in childhood, at the time that the brain is developing, may alter its growth, structure, and function. Anatomical and biochemical changes in the brain which has been exposed to long-lasting stresses are the subject of ongoing research.

With this perspective in mind, we posit in this book that any sexual offender who has a history of childhood trauma needs to be treated not only for the sexual offenses, but also for past trauma. This text therefore advocates that these traumas be addressed clinically; otherwise, they remain shadowy specters. These past "ghosts" are present but frequently unrecognized by offenders and their therapists. We also suggest that past traumas (e.g., child abuse and neglect) may present themselves in psychiatric co-morbidities in sex offenders. These psychiatric disorders require treatment simultaneously with therapy for offense behavior. Thus, an "offense-specific treatment program" should be "holistic." Such an approach gives some therapeutic attention not only to what the offender has done to the victim but also to what has been done to the offender as a child.

This book is divided into eight chapters. Chapter 1 addresses the issues of paraphilias and sexual offense behavior. Discussion of causal theories focuses on neurobiological aspects and epidemiology of paraphilias. Neuropsychiatric abnormalities in pedophilia and hypersexuality are explored as well as hypotheses regarding father/daughter incest. Included also is a reference to the "virgin cleansing myth" of South Africa. This superstition refers to the belief that having sex with a virgin (infant) may cure a man of HIV infection.

Chapter 2 focuses on the typology and characteristics of pedophil-

iacs and rapists. Child molesters' ego defense mechanisms and cognitive distortions are delineated. The chapter also considers the issue of possible guilt feelings that rapists and sexual offenders of children may experience in regard to their actions. Included is an exploration of the quality of such feelings: Are they genuine or pseudo-guilt, narcissistic, transitory ones connected to "getting caught"?

Further discussion deals with psychiatric co-morbidity in paraphiliacs and child molesters, with emphasis on substance abuse, mood disorders, and multiple paraphilic disorders in sexual offenders.

In Chapter 3 Drs. Sukosky and Marvasti explore the issues of sexual offense and hypersexuality in elderly males. Subjects include sexual function and aging, aging theories, biopsychosocial factors in elderly sexual offenders, neuropsychiatric syndromes associated with sexual aggression in demented elderly, and profiles of elderly sexual offenders. Materials in this chapter are based on the findings of recent research as well as the clinical observations of both authors in treating a number of elder sexual offenders (especially incest offenders) for the past 25 years.

Chapter 4 deals with psychotherapy for paraphiliacs and child molesters. The focus is on milieu intervention (e.g., inpatient psychiatric treatment, residential placement), and outpatient psychodynamic psychotherapy. Also noted are the "addiction model" of therapy for paraphilia and hypersexuality and the twelve-step program, Sexaholics Anonymous. Such therapies are discussed in the context of their premise that paraphiliacs exhibit the qualities of sexual "addiction."

This chapter also briefly reports on difficulties and barriers in treating sexual offenders, such as: (1) the problem of immediate gratification (PIG) in patients, (2) insufficient empathy from therapists, and (3) the negative attitude of the community toward paraphilia. For dealing with paraphiliacs, the authors advocate a humanistic approach, which includes empathy, respect, and "empathic confrontation," a type of psychotherapy that features the dual components of "kindness" and "firmness."

Chapter 5 centers on cognitive behavioral therapy, risk assessment, and relapse prevention for sexual offenders. Emphasis is on behavioral therapy, including covert sensitization, satiation techniques, fading, orgasmic reconditioning, and vicarious sensitization. This chapter also explores cognitive therapy's goals: challenging the

cognitive distortions universally present in sexual offenders and paraphiliacs and teaching the offenders "victim empathy." The author notes that the ability to "teach" empathy is debatable if the offender does not at least latently possess the quality. Also discussed is the fact that many molesters are deficient in social skills; training material on this subject is addressed especially for treatment of passive, shy, and socially phobic offenders.

Chapter 6 introduces the issues of pharmacotherapy and surgical castration of paraphiliacs and sexual offenders. Information follows on legislation in the state of California regarding mandatory chemical castration and the challenge by Dr. Fred Berlin (of Johns Hopkins University). Also included are descriptions of the neuroendocrinology of sexual behavior and the physiology of testosterone. The author then delineates the mechanism of action of anti-androgens, as well as outlining their side effects, indications, and contraindications. Besides medroxyprogesterone acetate (MPA) and cyproterone acetate, a few other medications, such as leuprolide acetate, triptorelin, and gonadotropine-releasing hormone (Gn-RH) agonists, are considered. The chapter also explores the psychopharmacologic treatment of co-morbidity disorders in paraphiliacs; the focus is on selective serotonin reuptake inhibitors (SSRI), antidepressant medications which may ease offenders' mood disorders and paraphiliacs' obsessive-compulsive characteristics.

Chapter 7 begins with a discussion of the biopsychosocial factors that may influence a victim of abuse to become a perpetrator of abuse. Information on the prevalence of this pattern is presented along with theories of the evolution of victimizing behavior. A brief description of types of psychological trauma is also presented.

A basic introduction to the neurobiological processes involved in memory and responses to traumatic events is discussed from a structural as well as a biochemical view. Emphasis is on the response of the limbic system in stress response and the role of neurohormones in this process. Next, information on memory formation is presented with discussion of the differences in the way pathology-inducing memories and "normal" memories are processed, integrated, and accessed. Finally, major symptoms related to the effects of traumatic stress are described.

Chapter 8 begins with a discussion of some of the behavioral responses that may follow exposure to trauma. A general description

of the goal of treatment is presented, followed by information on the most common forms of therapy currently in use–pharmacological treatment and cognitive behavioral approaches to treatment. Pharmacological agents include serotonergic agents, antiadrenergic agents, monoamine oxidase inhibitors (MAOI), tricyclics antidepressants, benzodiazepines and anticonvulsants. Cognitive behavioral approaches to treatment described are stress inoculation training, in vivo exposure and flooding.

J.A.M.

ACKNOWLEDGMENT

This book could not have been written without the help and support of many professionals and friends. My deepest gratitude to Suzanne M. Sgroi, M.D. for the endless hours of guidance she provided me.

My appreciation is extended to Lisa (Rogers) Schoendorf, Annette M. Corey, and Allen G. Marschat, my friends at "Team Works," for organizing and editing the manuscript and references. Manchester Memorial Hospital librarian Jeannine Gluck provided many articles and books for this project.

My thanks to Rena Foley, for her support and help, to my friends from Manchester Memorial Hospital, Diana S. Hawbaker, Maja Florentine, and John Hanna who were my "right hand" in writing, typing, and editing. I would also like to thank Susan F. Roche for her assistance in editing and to Mohammad K. Vafadar from North Dakota State University, who worked diligently preparing the text for publication.

CONTENTS

PSYCHIATRIC TREATMENT OF SEXUAL OFFENDERS

Chapter 1

PARAPHILIAS AND SEXUAL OFFENSE BEHAVIORS: ETIOLOGY, EPIDEMIOLOGY, AND DIAGNOSIS

JAMSHID A. MARVASTI

WHAT IS PARAPHILIA?

Random House Dictionary (1987) defined the word *paraphilia* as a type of mental disorder characterized by an obsession with unusual sexual practices.

Paraphilia is a name assigned to a deviant sexual arousal, characterized by being compulsive, intense, recurrent, and preferential in nature. Statistics show more than 95 percent of paraphiliacs are male and that this sexual disorder is generally ego-syntonic for most paraphiliacs; that means they are not disturbed by it.

Paraphilia is also divided into exclusive and nonexclusive categories. In nonexclusive types, the person may be stimulated by both the paraphilic stimuli and other types of sexual stimuli (Lopiccolo and Van Male, 1997).

DSM-IV focuses on common paraphilias such as exhibitionism, fetishism, frotteurism, pedophilia, masochism, sadism, transvestic fetishism, and voyeurism. It also includes "paraphilias not otherwise specified" (NOS), such as telephone scatologia, necrophilia, partialism, zoophilia, coprophilia, urophilia, and autoerotic asphyxia (*DSM-IV,* 1994).

One of the criteria for a diagnosis of paraphilia is the person expe-

riences clinically significant distress or impairment in social, occupational, or other important areas of functioning due to the paraphiliac activity, fantasies, or urges. Kafka (2001) noted that individuals who repetitively cross-dress or utilize fetishistic objects for sexual excitement, but are not disturbed by these behaviors and lack functional impairments, could not be classified as paraphiliacs.

Most sexual offenders cannot be classified or diagnosed as paraphiliacs and there are significant differences between these classifications. McElroy et al. (1999) studied 36 men convicted of sexual offenses. Among them only 58 percent could be diagnosed with paraphilias. *Sexual offender* is a legal term and not a psychological classification. *Perpetrator* and *rapist* are also legal terms. A *child molester* refers to anyone who sexually molests a child regardless of legal status or his or her sexual preference. However, *pedophilia* is a clinical and psychiatric diagnosis indicating a sexual disorder characterized by the presence of deviant sexual fantasies involving children and possibly, but not necessarily, deviant behavior (Cohen and Galynker, 2002).

Reid (1997) recommends distinguishing among those paraphilias that do not intrude upon other people (such as fetishism), or intrude but are nonviolent (exhibitionism), from intrusive and aggressive behavior toward others, such as pedophilia.

What are Paraphilia Related Disorders (Hypersexual Disorders)?

Paraphilia related disorders are described with different names such as "compulsive sexual behavior," "sexual addiction," "hypersexual disorder," and "nonparaphilic compulsive sexual behavior." The term *hypersexual disorder* will be used for the remainder of this section, because it is the most descriptive name for paraphilia related disorders. Although there is no official psychiatric diagnosis such as hypersexual disorder, Stein et al. (2000), after reviewing the literature, proposed adding a new category of "hypersexual disorder," to the *DSM,* which may supplement the diagnosis category of paraphilia.

Hypersexual disorder is defined as a disorder of quantity rather than quality. This disorder is a disturbance in intensity of conventional sexual functioning, such as masturbation or use of pornography. Hypersexual disorder is characterized by excessive use of sexual behavior in a compulsive way that becomes a source of distress to the

person or to those individuals around him or her. Paraphilias involves a disorder of sexual object or aim. By contrast, hypersexual disorder involves the abnormal quantity and strength of the individual's sexual drive toward otherwise conventional objects (Krueger and Kaplan, 2001a).

There are indications that these two disorders, paraphilia and hypersexuality, frequently co-exist. In a sample of 143 individuals with paraphilias, 86 percent also reported at least one lifetime "paraphilia related disorder" (Kafka and Hennen, 1999).

Krueger and Kaplan (2001a) noticed paraphilias and hypersexual disorder often co-occur and have some similarities from the point of view of phenomenology and co-morbidity. They reported both disorders begin in adolescence, involve mostly males, and are not associated with any special personality types or other psychometric predictors.

These authors described hypersexual disorder as a condition which involves "recurrent, intense, sexually arousing fantasies, sexual urges or behaviors persisting over a period of at least six months and does not fall under the definition of paraphilias." Krueger and Kaplan (2001a) also suggested that to fit diagnostic criteria, this disorder should be intense enough to cause significant distress in social, occupational, or other important areas of the individual's functioning. They also defined hypersexual disorder as a condition that cannot be accounted for by another Axis I diagnosis such as manic-depressive disorder or attributed to the direct physiological effects of substance abuse or a general medical condition.

Kafka (2000) gave several examples of hypersexual disorders, such as:

1. *Compulsive masturbation* to the point that masturbation is the primary sexual outlet, even if the person has a stable sexual relationship with a partner.

2. *Excessive promiscuity,* such as a pattern of involvement in one-night stands; use of prostitutes; "cruising"; brief or protracted, repetitive sexual affairs; or use of escort services.

3. *Dependency on pornography* or Internet pornography addiction.

4. *Telephone sex dependency* and *cyber sex dependency* at a significantly time consuming and financially costly level. *Cyber sex* is considered when an individual becomes excessively involved with Internet-related sexually oriented "chat rooms" or any Internet erotic site primarily used to stimulate sexual arousal.