Chapter Twenty-Four

Sexual Offending in Psychotic Patients

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Introduction

In this chapter, we will discuss sexual offending behavior perpetrated by those individuals who suffer from psychotic mental illness (MI) including schizophrenia, bipolar disorder, delusional disorder, and atypical psychoses. The diagnosis of MI is often comorbidly associated with other disorders such as personality disorder and intellectually disabilities. Here we intend to concentrate on those with severe and enduring mental health difficulties. While there is relatively good consensus among researchers and clinicians about the diagnoses of schizophrenia (Hodgins, 2004), and the assessment and treatment of sexual offenders (Beech, Craig, & Browne, 2009), there is a shortage of research on the assessment and treatment of sexual offenders with psychotic MI (Garrett & Thomas-Peter, 2009). As Hodge and Renwick (2002) argue, "there has been a general lack of consideration given to the factors underpinning mentally disordered offenders . . . and examination of motivational issues in this population is long overdue" (p. 221). This is particularly true for sexual offenders with psychotic MI, and as a result, relatively little attention has been paid to the assessment and treatment of those with psychotic MI who display sexually abusive behaviors.

International Perspectives on the Assessment and Treatment of Sexual Offenders: Theory, Practice and Research, Edited by Douglas P. Boer, Reinhard Eher, Michael H. Miner, Friedemann Pfäfflin, and Leam A. Craig. Published 2011 by John Wiley & Sons, Ltd.

Schizophrenia affects less than 1% of adult men and women and bipolar disorders approximately 1.6%. However, persons who develop psychotic MI are more likely to be convicted of criminal offenses than those without mental disorder (Hodgins, 2004). A number of studies have reported higher prevalence rates for major mental disorders among convicted offenders than those among age and matched samples (Brinded *et al.*, 1999; Brink, Doherty, & Boer, 2001; Brooke, Taylor, Gunn, & Maden, 1996). Singleton, Meltzer, Gatward, Coid, and Deasy (1998), on behalf of the Department of Health, sought to establish a baseline of the prevalence of psychiatric problems among prisoners in England and Wales. From 3,142 full interviews at the initial stage and 505 follow-up interviews, Singleton *et al.* found that 10% of men on remand and 7% of sentenced men were assessed as having a functional psychosis (such as schizophrenia or manic depression) in the year prior to interview. However, the number of psychotic patients who commit sexually abusive behaviors is less well known. UK Home Office statistics on restricted patients with MI (a subgroup of patients detained compulsorily under the Mental Health Act, 1983), and a history of sexual offending, increased from 8.9% of all restricted patients admitted to National Health Service (NHS) secure mental health facilities in 1983, to 9.5% in 1994 (Sahota & Chesterman, 1998). However, these figures decreased in 2002 to 7.8% (Home Office, 2003). When considering unrestricted hospital inpatients, the proportion of sexual offenders with MI has not changed significantly over the period 1992–2002; 5.9% in 1992, compared with 5.3% in 2002.

It is argued less than 8% of men charged with sexual offenses have an underlying mental illness (Sahota & Chesterman, 1998) and only 0.3% of men charged with rape have a MI (Craissati & Hodes, 1992). While the prevalence rates of MI may be higher in offending populations than nonoffending populations, Sahota and Chesterman (1998) point out that there are few individuals for whom MI is said to be the cause of sexual offending. Nevertheless, there are reports of patients who experience command hallucinations in the context of a schizophrenic illness, having sexually offended as a direct response to auditory hallucinations (Jones, Huckele, & Tanaghow, 1992).

When considering the assessment and treatment of sexual offenders with MI it is important to establish a sound psychological formulation (see Chapter 2) in order to identify the etiology of the offending behavior (Sahota & Chesterman, 1998). A number of theories have been developed to explain sexual offending behavior (see Ward, Polaschek, & Beech, 2006). Rather than reviewing and summarizing the current theories of sexual offending, in this chapter we will consider the behavior of sexual offending from a psychodynamic and neurobiological perspective within a psychiatric framework.

Psychodynamic and neurobiological perspectives

Psychodynamic theories basically support that various emotions of fear and sexual or personal inadequacy, sexual and personal, along with the possible

existence of unrecognized homosexual tendencies, interact with aggressiveness and are directed towards the victim as a substitute for mother, resulting in sexual abuse.

Feminist theory regards rape as a pseudo-sexual act induced by the sociopolitical domination of men. During the 1970s rape was a major issue for the feminist movement, a fact which at least partially was attributed to the belief that this form of violence was due to the change of roles which women gradually experienced. It was cited that not only rape but also the fear of a potential rape serves a mechanism of social control (Brownmiller, 1975).

The behaviorist model of "emotional state augmentation" supports that nonsexual emotional situations act complicatedly with sexual stimulation, in order to induce sexual response. This is a possible mechanism which is implicated in the positive (love) and the negative (hate) interactions of a relationship. The model of "state disinhibition of arousal" suggests that the nonconsensus pain and suffocation on behalf of the victim, as well as the emotions of fear, cause the inhibition of rape stimulation in most men. The mechanism in question is regulated by the ability of a person to empathize. The following dysfunctional mechanisms defined, concerning the insights or the beliefs of the sexually aggressive men: (1) Hyperperception of hostility/seductiveness, meaning that aggressive men have difficulty in discriminating between friendliness and provocativeness and between claim and animosity. (2) Negative blindness, meaning that sexually aggressive men are incompetent to realize the negative female signs. (3) Suspicious attitude, meaning that the sexual aggressive men regard the female sexual behavior and its relations as unreliable (Malamuth & Brown, 1994).

In the socio-biological theory of Ellis (1989), the biological variables have evolutionary meaning. According to this theory, men in contradiction with women, tend to maximize their capacity to mate by having sexual intercourse with many different partners. Ellis' theory clearly suggests an almost sexual incitement in rape, a fact which contradicts the feminist views and those on social learning. It also suggests that the nonsexual dimensions of the rapists' behavior, such as the aggressive and dominative behavior, should be regarded as a strategy rather than a target.

Certain research in prisoners showed that prisoners with a record of violent crimes had higher testosterone levels, in relation to those with no such record, while research on the relation between androgens and sexual aggressiveness showed controversial results (Dabbs, 1997; Giotakos, Markianos, Vaidakis, & Christodoulou, 2004). Several researches have described the more or less successful confrontation of sexual aggressiveness using the antiandrogens medroxyprogesterone acetate (MPA) and cyproterone acetate (CPA) (Weiss, 1999). The first, effecting directly to the testosterone, inhibits the excretion of gonadotropins, and the second competes directly with the effect of testosterone into the receptor of the target organ, resulting to the reduction of the levels of testosterone. In addition, suppression of the hypothalamic-pituitary-gonadal axis by a GnRH (Gonadotropin Releasing Hormone) agonist

seemed to reduce at a great extend both the testosterone levels and sexually aggressive behaviors (Rosler & Witztum 1998).

There is increasing evidence for the use of selective serotonin reuptake inhibitors (SSRIs) (Beech & Mitchell, 2005) in treating and managing sexual arousal in sexual offenders. There is evidence that the use of SSRIs, such as Prozac (fluoxetine hydrochloride), Luvox (fluvoxamine maleate), Seroxat (paroxetine hydrochloride) and Zoloft (sertraline hydrochloride) in the treatment of sexual offending has been increasing over the past few years. SSRIs inhibit the reuptake of 5-hydroxytryptamine (5HT) as part of a much more widespread effect on neurotransmitters (or monoamines). It has been argued that adverse childhood experiences such as abuse, stress, and insecure attachment produce biochemical changes in the areas of the limbic areas of the brain that modulate attachment behaviors. Beech and Mitchell (2005) argue that poor attachment in childhood and the consequent increased exposure to stressors results in reduced serotonin 5HT levels, oxytocin and vasopressin function and raised corticosteroid release, which can result in hippocampal and striatal damage. Although the number of studies reporting the use of SSRI in reducing sexual offending are small, Pearson (1990), Coleman (1991), and Kafka and Coleman (1991) were probably the first to suggest that problematic 5HT transmission underlies paraphilic disorder. Kafka (2003) notes that there are now over 200 examples of the positive uses of SSRIs for the treatment of paraphilias (deviant sexual urges) or paraphilic disorders, although most of those reported are single case studies (Adi *et al.*, 2002). In their review of the neurobiological perspective on attachment in sexual offenders, Beech and Mitchell (2005) note a number of studies have reported improvements when using SSRIs including decreases in deviant fantasies, reductions in unconventional/abnormal/paraphilic sexual behaviors and reductions in obsessions/compulsions regarding aberrant sexual behavior. The inclusion of SSRI in treatment carried out in conjunction with traditional cognitive-behavioral therapy has been reported to be effective in the treatment of sexual offenders (Friendship, Mann, & Beech, 2003; Hanson *et al.*, 2002). The use of SSRIs might also be useful as an adjunct to schema based interventions that are beginning to be used for sexual offenders (Mann & Beech, 2003). This approach addresses enduring personality characteristics and deficits arising from childhood problems such as abuse, neglect and insecure attachment.

Psychopathology

There is compelling evidence to support a small but significant association between mental illness and violence generally (Modestin & Ammann, 1996; Mullen, 2000). Persons who develop MI are more likely than persons with no MI to be convicted of criminal offenses (Hodgins, 2004). In nonoffender populations, higher rates of sexually deviant fantasy and behaviors have been found

among psychiatric inpatients, compared to nonmentally ill individuals (Alvarez & Freinhar, 1991). The relationship between major mental illness (e.g., schizophrenia) and sexually offensive behavior is complex and not well understood. Studies suggest that less than 8% of men charged with sexual offenses have an underlying mental illness and there are few individuals for whom mental illness is said to be the cause of sexual offending (Sahota & Chesterman, 1998). Craissati and Hodes (1992) report that police records show that only 0.3% of men charged with rape have a MI. Nevertheless, there are reports of patients who report experiencing command hallucinations in the context of a schizophrenic illness having sexual offended as a direct response to auditory hallucinations (Jones *et al.*, 1992). Individuals diagnosed with schizophrenia are approximately four times more likely to have been convicted of a serious sexual offense than their nonmentally ill counterparts (Wallace *et al.*, 1998). In a sample of 100 prisoners convicted for rape or child molestation, half of them had a life-time history of Axis I disorders and the two thirds had an Axis II diagnosis (Giotakos, Markianos, Vaidakis, & Christodoulou, 2003, 2004). Abel, Becker, Cunningham-Rathner, Mittleman, & Rouleau (1988) found that 5% of child molesters appear to be psychotic, although this is a small number. In another sample, one-third of rapists were diagnosed with depression, while two-thirds were diagnosed with overuse or dependability from alcohol (Hillbrand, Foster, & Hirt, 1990). Further studies have reported high frequency of stress disorders (Dewhurst, Moore, & Alfano, 1992), while others (Seghorn, Prentky, & Boucher, 1987) found 7% schizophrenia, 2% schizo-emotional disorder, 5% major depression, and 6% organic psycho syndrome. It is regarded that these percentages are higher than the average total population of prisons. The 60% of those who were convicted for rape in New Zealand met the diagnosis criteria of Axis I, according to DSM-III-R (American Psychiatric Association, 1994), without bearing in mind the alcohol or other substances overuse (Hudson & Ward, 1997).

Examining the disorders of Axis II (Personality Disorders), Seghorn *et al.* (1987) observed that almost one-third of the sample presented with a personality disorder, while other researchers found higher levels, even up to 90% (Berner, Berger, Gutierez, Jordan, & Berger, 1992). Regarding sexual offenders' personality, studies have shown that they share some common characteristics, like impulsivity, multiple offensiveness, and difficulty in understanding other's emotions. In addition, the presence of antisocial/psychopathetic personality features seems to be a prognostic factor not only for the most violent sexual crimes, but also for the relapse to a general type of crimes (Hanson *et al.*, 2002). Some models of sexual aggressiveness focus mostly on the antisocial personality characteristics and less on other characteristics (Marshall & Barbaree, 1988).

Static predictors of risk for general and violent (nonsexual) recidivism include: being at a younger age and being single; lifestyle instability, history of rule violations, alcohol and drug abuse, antisocial behavior, and history of violent crimes (Gendreau, Little, & Goggin, 1996; Hanson & Bussière, 1998). As an

indicator of the presence of antisocial personality traits these factors have a consistent and strong relationship with recidivism (Andrews & Bonta, 2003; Quinsey, Harris, Rice, & Cormier, 2006). In their updated metaanalysis, Hanson and Morton-Bourgon (2005) confirmed that the major predictor of general and violent recidivism among sexual offenders was an antisocial orientation, demonstrated by antisocial traits and personality and a history of rule violations.

Additionally, a higher rate of substance abuse is often reported. The use of alcohol in some societies is used as an excuse for rape and sexual assault. It is used to explain a lack of responsibility both for the perpetrator's actions and for the victim's alleged compliance. Indeed, Grubin and Gunn (1990) observed a high prevalence of alcohol use among rapists in the United Kingdom; 58% of men convicted for rape had been drinking prior to the offense and 37% were considered to be dependent on alcohol. At least half of the prisoners convicted of rape were found to have consumed an excessive quantity of alcohol just before the rape (Seto & Barbaree, 1995), with alcohol being related to sexual aggressiveness (Marshall, 1996).

Psychotic patients – early life experiences

Studies of the impact of child physical and sexual abuse have tended to indicate a relationship with adult psychopathology, particularly depression, substance abuse, and personality disorder (Wexler, Lyons, Lyons, & Mazure, 1997). In general, studies of the impact of early life experiences have demonstrated an association between childhood abuse and a range of adult deviant sexual behaviors, in particular a link between childhood sexual abuse and pedophilia (Salter *et al.*, 2003). One study showed a similar or reduced incidence of child abuse in those with schizophrenia compared with control groups or those with other psychiatric disorders (Wexler *et al.*, 1997). Another study (Adams, Harper, Knudson, & Revilla, 1994) examined the clinical correlates of sexually deviant behavior in a group of approximately 500 adolescents with a range psychotic, affective, and behavioral diagnoses. While there was no evidence for sexual deviance in over half the sample, 41% engaged in persistent hypersexual activities, exhibitionism, or sexually victimizing behavior including molestation and rape. The deviant adolescents were significantly more likely than nondeviant subjects to have experienced prior physical abuse (66% v. 52%). Also, significantly more sexually deviant adolescents had documented histories of childhood sexual abuse (82% v. 36%).

A question often asked is how sexual abuse in childhood sometimes leads to sexual offending in a given individual? Although there are a number of theories that attempt to explain this (Ward *et al.*, 2006), the most parsimonious explanation (from a psychodynamic and neurobiological perspective within a psychiatric framework) is that progression from victim to offender is more

likely when the abuse and reactions to the abuse by the victim and those around him or her lead to distortions in the victim's perceptions of normal sexuality. As noted earlier, this may lead to biochemical changes in areas of the limbic area of the brain that modulate attachment behaviors (Beech and Mitchell, 2005). These distortions may then develop into maladaptive cognitive processing or psychological vulnerabilities and belief structures that increase one's vulnerability to offend sexually (see Beech & Ward, 2004). Clearly this is an oversimplification of what is a complex and multifactorial process which is captured by the Beech and Ward's (2004) Integrated Theory of Sexual Offending.

Preexisting paraphilia

Exhibitionism, as an example of an atypical sexual outlet, has previously been related to rape offenses (Paitich, Langevin, Freeman, Mann, & Handy, 1977). Gebhard *et al.* (1965) suggested that one in 10 exhibitionists have seriously thought about or attempted rape. Abel *et al.*'s (1988) research found that out of 126 rapists who were examined, 44% had sexually assaulted girls outside the family circle, while 14% had additionally assaulted boys outside the family circle. However, several significant differences between rapists and pedophiles, related to the characteristics of the adult and the former development phase have been found.

Sexual assaults by strangers are those most often reported to the police and represent 36% of all reported rapes. This gives a distorted picture of the prevalence of rape by someone known to the victim. Date rape, acquaintance and marital rape are much less likely to be reported to the police but according to prevalence studies, such as the British Crime Survey, appear to be more common (45% of rapes as opposed to 8% by strangers). There are few significant differences between rapists and other men who commit serious crime (Brownmiller, 1975). All are likely to have low school achievement with a history of truancy, unstable family backgrounds, poor employment records, and few social competences (Hudson & Ward, 1997). Furthermore, levels of psychosis, serious brain dysfunction or intellectual disabilities among adult rapists (5% to 8%) are similar to the general population (Marshall, 2000).

Rapists, compared with pedophiles, tend to be younger (see Craig, 2008), impose themselves (aggressive) rather than being imposed to (passive), have been married or connected with a woman for a satisfactory period, and tend to rarely present mental deficiency or some organic brain syndrome compared to child molesters (Hudson & Ward, 1997). During the development stages, rapists compared to pedophiles, tend to come from nondivorced parents, do not have relatives with psychiatric record, have half possibilities to have experienced sexual assault, have not presented significant health problems, but have abused animals and have demonstrated problematic behavior in school (Bard *et al.*, 1987).

For some individuals paraphilic arousal predate the onset of psychiatric symptoms. Mental illness also may have an impact on the expression of that paraphilia. The mental illness may exacerbate the deviant behavior, through its disinhibiting effects on deviant thoughts, or the influence of delusions or hallucinations. Alternatively, paraphilic sexual behavior may diminish as a result of decreased libido, disorganization, or anxiety. The negative symptoms of schizophrenia and the sedative effects of antipsychotic medication may also influence the patient's capacity to meet his sexual needs in socially appropriate ways. In a comprehensive set of studies, Smith and Taylor (1999a) reviewed the files of 84 sexual offenders with a diagnosis of schizophrenia. In 80 cases these crimes were committed while the men were actively psychotic, but the authors identified 23 men who sexually offended prior to the onset of schizophrenia. The same authors found that the schizophrenic sexual offenders with aggressive sexual fantasies at the time of their index were significantly more likely than those who denied such fantasies, to have a history of sexual offending prior to the onset of schizophrenia. These data suggest that in some instances sexual deviance may predate the onset of schizophrenia, although it is important to note this research does not propose a causal relationship between the two.

Positive and negative symptoms of schizophrenia in sexual offenders

Sexually related hallucinations or delusions may directly influence the appearance of sexually offensive activities. In the Smith and Taylor (1999b) study mentioned previously almost all the schizophrenic sex offenders reported delusions and/or hallucinations at the time of the index offense. Some 43% of the sample had delusions and 33% had hallucinations that were directly or indirectly related to the offense. Thus, the content of delusions and hallucinations would appear to be relevant to sexual offending in at least some mentally ill patients. Regarding the disinhibition or impulsivity, patients with schizophrenia have a reduction in the capacity to inhibit inappropriate behaviors in general. Also, their deviant thoughts may be experienced as occurring spontaneously, and the patient acts on his desire with little control, thought, or reflection.

Social withdrawal, lack of volition and cognitive deterioration compromise the individual's ability to fulfill his sexual needs in socially appropriate ways and thus increase the risk of inappropriate acts. Control of such behavior is largely dependent on treatment of the mental illness and attention to negative symptoms. For these reasons, sexual offenders with schizophrenia may also benefit from educative approaches, as well as social skills and victim empathy training (Garrett & Thomas-Peter, 2009). The executive functions also play a pivotal role in the initiation and enactment of appropriate behaviors. Reduced attention and verbal memory have also been implicated in misperception of social cues and poor social problem-solving. These deficits could give rise to inappropriate sexual behavior.

Sexual functioning and violence

A series of common features in the sexual record of perpetrators of sexual violence have been identified. Men who present high levels of sexual aggressiveness seem to have had early and often more loose sexual experiences of sexuality generally and also presented indications of increased morbidity related to paraphilia, as well as increased occupation with pornography. It is commonly accepted that a significant number of rapists have been sexually assaulted during their childhood or have witnessed deviating sexual activity. However, not all those assaulted during childhood present sexual aggressiveness. This fact indicates the existence of other factors which intervene in the course of development of sexual activity, such as the desire to humiliate the victim and the lack of empathy. Several researchers observed that dynamic factors such as social isolation, feelings of inadequacy, and lack of adult intimate sexual relationships impact on sexual recidivism (Beech, 1998; Hanson *et al.*, 2007; Thornton, 2002). In addition, the sexual offenders who had many relationships describe them as superficial. The common element among adult sexual offenders is the failure to contract an intimate sexual relationship, which leads them to isolation. Repeat sexual offenders presented greater difficulties in developing a sexual relationship, distorted attitudes, and obtained poorer scores on the socio-affective functioning and poorer self-management than first-time offenders (Thornton, 2002). Similar were the results among prisoners convicted for sexual offenses, while especially those charged with incest, compared separately with rapists and nonsexual offenders, present higher levels of fear for developing an intimate sexual relationship, while rapists compared with pedophiles present low desire for an intimate relationship with other men and members of their family (Marshall, 1996).

In a sample of sexual and violent offenders referred to a UK Regional [Medium] Secure Unit for adult psychiatric patients and mentally disordered offenders it was observed that offenders who had been convicted for sexual violence were often convicted for nonsexual crimes as well as new sexual offenses (Craig, Browne, Beech, & Stringer, 2004). Antisocial personality traits, and in particular impulsivity (Craig *et al.*, 2004), may be instrumental in the production of sexually aberrant behaviors. Some individuals exhibit antisocial conduct prior to the onset of schizophrenia, which may continue to impact on behavior after the development of the disorder. It is also important to consider the contribution of substance abuse to sexually offensive conduct in schizophrenic patients, via mechanisms that include disinhibition, interpersonal impairment, and diminished social and sexual functioning. Substance misuse may also contribute to aberrant sexual activities by reducing control over the deviant urges of patients with preexisting paraphilias, and by augmenting violent proclivities in general (Gebhard *et al.*, 1965; Hanson & Morton-Bourgon, 2005).

The deficits in social and sexual functioning described in schizophrenia are important considerations in any assessment of deviant sexual behavior.

Untreated schizophrenia has been found to have a negative impact on sexual functioning, with sufferers reporting decreased sexual thoughts and desire (Ainsworth, Aizenberrg, Zemishlany, Dorfman-Etrog, & Weizman, 1995). When individuals with schizophrenia engage in intimate activities their actions are likely to be perceived by potential romantic partners as poorly communicated and primitively enacted (Skopec, Rosenberg, & Tucker, 1976). Johnston and Planansky (1968) argue that schizophrenia has a negative impact on relationships, with many married females reporting diminished sexual attraction to their husbands because of perceived illness-related changes. Also, the majority of Johnston and Planansky's (1968) schizophrenic inpatients who committed contact sexual offenses against women had ongoing heterosocial difficulties.

Treatment

Examples of integrated programs on sexual offenders come from the United States, Canada, Australia and the United Kingdom (Marshall *et al.*, 1998). In general, the interventions to confront the sexual offenders are distinguished in those that are performed in prisons and those that are performed within the community, in other words on persons who are under surveillance or probation supervision or have just been released from prison. The therapeutic programs for confronting sexual crime prisoners are usually in the form of group therapy. The primary goals are: (1) settlement of minimization issues and resumption of responsibility, (2) definition of the circle or the procedure which results to crime, (3) definition and supervision of individual therapeutic goals, (4) learning the prevention methods and (5) help to embody therapeutic material from other groups. The group also acquires training in basic social skills, such as communication skills, empathy towards the victim, anger management, stress management, sexual hygiene and so forth. Certain risk estimation instruments, such as the Sex Offenders Risk Appraisal Guide (SORAG: Quinsey *et al.*, 2006), Static-99 (Hanson & Thornton, 2000), Static-2002 (Hanson & Thornton, 2003) and Risk Matrix 2000 (Thornton *et al.*, 2003) which record various prognostic parameters, showed strong capacity to forecast the relapse of sexual or general forms of crime (see Craig, Browne, & Beech, 2008). A recent research study in Belgium (Ducro & Pham, 2006) demonstrated the ability of these instruments and it was also found that within 4 years of surveillance the relapse in sexual offenses was 25%, while the relapse in general offenses was 33%. A recent metaanalysis of 82 studies which examined the sexual reconviction rate in 29,450 sexual offenders (Hanson & Morton-Bourgon, 2005) found that the deviating sexual behavior and the antisocial (psychopathic) personality structure, are the two major factors of relapse. The idea of a "dual dimension" to sexual offending comprising of sexual deviance and antisociality as also been reported elsewhere (Roberts, Doren, & Thornton, 2002). In addition, the

antisociality/psycho passivity is a prognosis factor not only for the most violent sexual crimes but for the relapse in general types of crime.

At present, mentally ill sex offenders are poorly served by treatment programs traditionally designed for their nonmentally ill counterparts. They receive little assistance from a mental health system that lacks expertise in the management of sexual deviance. Despite the fact that they are believed to account for less than 10% of sexual offenses (Sahota & Chesterman, 1998), their often complex nature and multiple pathologies means they require a high level of resources to receive adequate assessment and treatment. Treatment for these individuals must take account of the premorbid sexual pathology and any complicating illness-related factors, including sexual and social dysfunction. Comprehensive cognitive behavioral approaches are indicated (Marshall *et al.*, 1999), adapted to the individual needs and capabilities of the patient. In those with uncontrollable deviant thoughts and those who have difficulty mastering cognitive techniques, consideration should be given to adjunctive libido-suppressing medication. This is usually best achieved with regular depot injections of synthetic hormonal preparations such as Depo-Provera, or GnRH agonists (Bradford, 1997). Baseline investigations and physical examination, informed consent and medical monitoring are essential components of hormonal treatment programs.

Conclusions

Some studies have found an elevated incidence of violent sexual offenses in males with psychotic disorders. This chapter reviewed the research on the etiology of sexual deviance in schizophrenia focusing on the role of early childhood experiences, deviant sexual preference, antisocial personality traits, and psychiatric symptomatology. Some studies have proposed that schizophrenic patients who engage in sexual offensive activities fall into the following four groups: (1) those with a preexisting paraphilia, (2) those whose deviant sexuality is the manifestation of an antisocial behavior, (3) those whose deviant sexuality arises in the context of illness, and (4) those with substance use. Treatment for sexual offenders with schizophrenia needs to be integrated, taking into account multiple elements such as delusions, antisocial personality traits, a past history of deviant sexual behaviors, and substance abuse. This approach necessitates especially structured long-term programs.

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