Commentary: Sex Offenders and Insanity

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Sex offenders with a psychotic illness present challenges in the determination of criminal responsibility, risk assessment, and psychiatric treatment. Novak *et al.* present data that raise concerns regarding how forensic psychiatrists could conclude sex offenders were not responsible for their offenses in the absence of clear evidence of psychotic symptoms at the time of assessment and/or offense. They also highlight issues of risk assessment and management of psychotic sex offenders that have not been adequately studied. We require further research of psychotic sex offenders to be able to offer scientifically supported opinions on risk assessment to courts and decision-makers.

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The paper by Novak *et al.*[1] has raised stimulating questions regarding how to manage sex offenders who may have a psychotic illness. In describing their sample of 42 sex offenders found not guilty by reason of insanity (NGRI), they have raised three questions that have not been adequately addressed in the existing psychiatric literature and require further study. These include difficulties in objectively evaluating the quality of insanity evaluations by psychiatrists, the role of psychotic illness in sexual offending, and the difficulties in assessing risk in sex offenders who have a psychotic illness.

The study is one of the few that has attempted to evaluate objectively the quality of psychiatric opinions in those persons found NGRI. The authors note the inherent methodological difficulties in a file review of psychiatric reports. There is limited information regarding the process the psychiatrists used in reaching a diagnosis or in how it played a role in forming their final opinion regarding criminal responsibility. There has been a lack of clarity about critical factors such as influence of substance abuse and its potential role in diagnosing or misdiagnosing psychotic illness. The authors also noted that 6 of the 21 child molesters demonstrated no evidence of hallucinations or delusions, raising substantial questions as to how they could have been found NGRI.

Borum and Grisso[2] surveyed forensic psychiatrists and psychologists for their opinions regarding content of forensic reports for use in determination of criminal responsibility. They noted significant consensus regarding content and information but pointed out that this simply reflected opinion and not actual behavior. Psychiatrists and psychologists agreed it was "essential" for an opinion regarding the nature of the mental disorder and its relationship to criminal responsibility. The description of the forensic psychiatric opinions in the Novak *et al.*[1] study seem to fall short of the consensus of forensic psychiatrists and psychologists in the Borum and Grisso survey. To evaluate more fully the quality and accuracy of actual psychiatric opinions on legal sanity one would need much greater information including the review of psychiatric testimony at trial and of the actual evidence presented in the case.

The authors note that while certain psychiatric disorders including mood and anxiety disorders, substance abuse disorders, and personality disorders are common among sex offenders, psychotic illness is uncommon in convicted sex offenders. The study of any socially deviant group such as those who commit criminal acts will naturally have a higher rate of certain psychiatric disorders than the rest of the population. In part, this reflects forensic psychiatric diagnostic criteria, which often contain value statements

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as opposed to hard medical fact (e.g., the diagnostic criteria of antisocial personality disorder or paraphilia). It is also explained by the impact that psychiatric illness and personality difficulties have on an individual's capacity to form mature stable relationships, deal with stress, manage the complexities of life, and find fulfillment in more prosocial attitudes and behavior. Criminal groups such as the sex offenders are heterogeneous in their makeup and include a wide range of psychopathology. Novak *et al.*[1] appropriately comment that their study may reflect a sampling bias in that sex offenders found NGRI would be more likely to have more severe psychopathology, including psychotic illnesses, than those found guilty and incarcerated.

Mentally ill sex offenders have not been widely studied in North American populations but there are studies in European populations that provide further information worth reviewing. Chesterman and Sahota[3] reviewed 20 mentally ill sex offenders in secure hospitals in Britain and found a high incidence of family psychopathology, criminal behavior, and substance abuse in addition to the psychotic illness. In their small sample they concluded there was a relationship between the psychotic illness and the sex offending over and above other factors. Smith[4] examined the role of aggressive sexual fantasies in schizophrenic offenders who had an index sexual offense involving contact with the victim. Of the 80 male subjects hospitalized in any psychiatric hospital in Britain in the month of May 1997, 19 showed evidence of aggressive sexual fantasies at the time of the index offense. Thirteen of 19 showed evidence of sadistic sexual fantasy. Most subjects with evidence of deviant fantasies had a history of sexual offenses predating the onset of schizophrenia.

Langstrom *et al.*[5] reviewed the relationship between psychiatric disorder and criminal recidivism in a large Swedish cohort of sex offenders. Similar to American studies, alcohol abuse, personality disorder, and drug abuse were the most commonly diagnosed disorders but psychotic illness also increased the risk for sexual recidivism on follow-up studies. In a more recent study, Fazel *et al.*[6] reviewed psychiatric hospitalization among sex offenders in Sweden. They compared 8495 sex offenders with random control subjects and found sex offenders had a psychiatric hospitalization rate six times that of the general population. Sex offenders were 4.8 times more likely to receive a diagnosis of schizophrenia and 3.4 times more likely to have bipolar affective disorder. The authors noted, however, that the high rates of severe psychiatric illness were in contrast to other studies of convicted sex offenders.

There is a paucity of research on the management and treatment of sex offenders with a psychotic illness. It is likely that most clinicians would utilize the same treatments for psychotic illness in sex offenders as in other offenders. The more difficult problem is evaluating the risk of future offending in sex offenders with a psychotic illness. The authors raise questions as to whether the legal provisions associated with commitment to psychiatric hospitals following a finding of NGRI are sufficient to manage potential further risk once the psychotic illness has improved and they may be deemed no longer to suffer from a mental illness and therefore are released. They suggest the legal system may be faced with a dilemma and consider civil commitment under sexually violent predator statutes. Either system will be faced with how much weight to place on a history of psychosis as a risk factor. In a meta-analysis, Hanson and Bussiere[7] noted that a history of psychosis was a significant predictor of recidivism of sexual offenses but there was considerable variability in the studies. More stable predictors included deviant sexual arousal toward children, a history of personality disorder, especially antisocial personality disorder, prior sexual offenses, and the number of prior offenses. In general terms, risk factors are additive. We do not, however, have empirically derived guidelines on the interaction between psychosis and other risk factors.

There are now numerous formal risk assessment instruments designed to predict sexual recidivism in clinical and legal settings. None has been proven superior over the others.[8] Psychotic illness is found on only one instrument, the SORAG, where it is actually rated a protective factor and not a risk factor. This anomaly arose from the population studied in creating this particular instrument and should not be applied more universally. Other instruments provide no guidance on how to rate a history of psychosis.

Drake and Pathe[9] suggest a typology to begin addressing the relationship between psychosis and sex offending that may have clinical utility. They describe four groups including those whose sexual deviance arises during the course of their schizophrenic illness, those with a pre-existing paraphilia, those whose sexual offending is in the context of general

antisocial behavior, and a fourth category of "other." At this point, there are no data to support such a typology or classification.

While those with a diagnosis of schizophrenia or other psychotic illnesses make up a relatively small percentage of sex offenders, this small group presents a very large clinical and legal challenge. This population has not been adequately studied, and further information regarding their management and potential risk for reoffending is needed.

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