Sexual Offending and Antisocial Sexual Behavior Among Patients With Schizophrenia

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Background: A number of studies have indicated excessive offending behavior among people with schizophrenia; however, sexual offending has not been widely described.

Method: This study reports on a subgroup of 15 men with schizophrenia, diagnosed according to ICD-10 guidelines, in a secure hospital who had committed sexual offenses or shown antisocial sexual behavior. A comparison group comprised 55 male patients with schizophrenia and a history of violent behavior who were being treated in the same hospitals as the study group.

Results: In 12 of the 15 cases, the sexual offending/behavior postdated illness onset and occurred in the context of psychotic symptoms. Although 12 of the offenders were known to psychiatric services, contact was erratic and only 4 were taking medication. At assessment, those with sexual offenses or antisocial sexual behavior were twice as likely as the larger study sample to report unimpaired sexual interest. This may be of particular relevance in that the group also reported difficulty in forming close personal relationships.

Conclusion: Illness-related factors appear to make an important contribution to sexual offending by this group of patients, highlighting the need for comprehensive and vigorous treatment.

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The majority of those suffering from a mental illness have no history of offending or of violent behavior and pose no significant threat to others. There is increasing evidence, however, for a small but significant association between schizophrenia and violence toward others.[1,2] Specific illness-related factors have been implicated in the etiology of such violence,[3,4] which has been shown almost always to occur after illness onset.[5,6]

Although there is now a substantial literature regarding the issue of dangerousness and schizophrenia, there has been little investigation to date of patients with schizophrenia who commit sexual offenses or who have exhibited antisocial sexual behavior. From the limited information available, those with psychotic illnesses who commit sexual offenses appear to form a very small proportion of the general population of sex offenders.[7–12]

Although such patients are few, they may give rise to a considerable degree of public concern. National newspapers tend to sensationalize these patients, with descriptions such as "psychotic sex killer sent to Broadmoor"[13] and "detectives have been monitoring schizophrenic sex attacker for years."[14] Such press coverage, especially in the context of current public concern about the effectiveness and safety of community care, can give rise to a distorted public perception of the association of such offending with mental illness.

A number of investigators have suggested that sexual offending by this group may be directly linked with illness activity,[10,15] with some offenders acutely psychotic at the time of the offense. Illness-associated offending has been further linked with the suggestion that sexual offenses by the mentally ill may be particularly bizarre or violent and therefore especially disturbing for the victim.[10] Craissati and Hodes[16] have described a small series of mentally ill sex offenders admitted to a regional secure unit. Four of the 11 cases (10 of whom had a diagnosis of schizophrenia) in this series had no previous contact with psychiatric services but became acutely psychotic shortly before or soon after the offense. Although the remainder of the sample had a previous psychiatric history, only 1 was in contact with services and on medication at the time of the offense. There was clear evidence of a relapse preceding the offense in 3 of these cases. The authors described a complex relationship between illness and offending, with most offenses impulsively executed and associated with feelings of sexual disinhibition.

There have been reports of sexual offending being more directly associated with symptoms such as delusions or hallucinations. Jones et al.[15] described 4 cases of patients with schizophrenia who committed sexual assaults apparently as a direct response to command auditory hallucinations, although the small size of the sample limits

the extent to which these symptoms may be interpreted as having particular significance.

Preoccupation with a sexual or morbid sexual connotation has been recognized in association with schizophrenia. In addition, literature on erotomania indicates a common association with schizophrenia.[17] Such symptomatology may be linked with sexual offending or motivate nonsexual offending. Mullen and Pathe[18] have described a series of 14 patients with stalking behavior, 7 of whom suffered from schizophrenia, and 4 of these had committed sexual offenses.

The context of social and sexual functioning and sexually related symptomatology is likely to be relevant when considering sexual offending by those with mental illness. A range of disturbances of sexuality has been described in patients with schizophrenia,[12] and psychotic symptoms of a sexual nature are not unusual.[19,20] It is commonly thought that the later stages of illness are associated with decreased sexual interest, and, in addition, sexual dysfunction is a well-known complication of antipsychotic medication.[21] It has been suggested, however, that there may be an increase in sexual drive in early stages of illness.[22,23] In addition, Cournos et al.[24] have reported that over half of a group of patients with severe schizophrenia had a high sex drive. Maintained sexual drive and interest in the context of impaired sexual and social functioning may be particularly relevant in relation to sexual offending.[15,23]

Our study describes a group of patients with a primary diagnosis of schizophrenia and a history of sexual offending or seriously disturbed sexual behavior. This group was identified as part of a larger study of patients with schizophrenia and a history of offending or violent behavior who were being treated in 1 of the 3 special hospitals in England and Wales. These hospitals are part of the public health system. For admission to these hospitals, an individual must be subject to detention under the Mental Health Act 1983, be considered seriously and imminently dangerous, and require treatment in conditions of maximum security. Nearly all patients have committed serious violence prior to admission. Patients may be admitted from the judicial system following serious offending or may be transferred from other less secure hospitals, when violent behavior has not been able to be contained. The primary aim of the special hospitals is assessment and management of patients with mental disorders with offending/violent behavior. Length of admission is determined by mental state rather than being imposed by the judicial system.

METHOD

Case notes of all patients with a clinical diagnosis of schizophrenia, made according to ICD-10 guidelines, who resided in 1 of the 3 special hospitals during the first 6 months of 1993 were reviewed. A subgroup of this sample was defined for more detailed case-note review and interview. This subgroup comprised all the women (N = 32), all the Anglo-Caribbean men (N = 29), and a random sample of the white men (N = 41) who make up the majority of those with schizophrenia in the special hospitals. A standard random number table was used to select the sample of 41 from the total number of 183 white men. There were no significant differences between those in the random sample and the larger group of 183 in terms of age at assessment, age at hospital admission, range of offenses, or seriousness of violence prior to hospital admission.

Those patients with an index offense of a sexual nature, past offense of a sexual nature, or with seriously disinhibited, inappropriate, or offensive sexual behavior were identified from within this group of 102 patients.

Information was gathered from case notes, which included lengthy social work reports completed during the initial 6-month assessment period. A checklist (Appendix 1) was completed for each patient. The main categories of information collected included demographics, family history, social history, psychosexual history, and psychiatric and offending history. Those patients giving consent were interviewed using the Comprehensive Psychiatric Rating Scale (CPRS),[25] the Brief Psychiatric Rating Scale (BPRS),[26] the Social Dysfunction and Aggression Scale (SDAS),[27] and the Social Network Schedule.[28] Additional information provided by the primary nurse was also used in completing the Scale for the Assessment of Negative Symptoms (SANS).[29]

In addition, a comprehensive neuropsychological battery was completed. This included an estimate of general functioning (IQ) based on 5 subtests of the Wechsler Adult Intelligence Scale (WAIS-R[30]) and indications of literacy skills, memory efficiency, and speed of response from a series of more specialized tasks. Some consideration of response control in a cognitive setting was also obtained from the number of errors made in the conflict condition of the Stroop color/word task[31] and in the completion of a series of children's mazes.[32]

RESULTS

Fifteen men (7 Anglo-Caribbean and 8 white), 21% of the larger study group of 70 male patients, were identified as having an index or past offense of a sexual nature or of having a history of seriously disturbed or inappropriate sexual behavior. None of these 15 men had shown evidence of sexual deviance since their admission to the special hospital. None of the women had committed sexual offenses and were therefore not considered further in this study and were excluded from the analysis.

The mean age at illness onset for the group was 22 years (range, 15–41 years), the mean number of years ill at time of assessment was 17 years (range, 5–35 years), and

the mean age at assessment was 38 years (range, 26–55 years). The mean age at hospital admission was 31 years (range, 19–49 years), and the mean length of hospital admission at time of assessment was 7 years (range, 1–17 years). There was no significant difference in these measures between the group and the larger study sample.

Seven men had an index offense of a sexual nature. These men had committed between them a total of 14 offenses of rape or attempted rape (1 subject accounted for 7 of these offenses) and a further 8 offenses of indecent assault. The index offenses of these men also included a number of other offenses (total of 7 other offenses, including 2 homicides). Two of the men had previous convictions for rape. Although convictions for other violent offenses in the past were rare, 4 of these men did have a criminal record of more minor offenses. The pattern of offending for these men demonstrated some escalation in severity of offending.

Eight other men had a history of antisocial sexual behavior prior to admission for which no charges had been brought. Examples of such behavior included sexual assault and inappropriately touching women while demanding sexual intercourse. For those who had not actually been charged in relation to their antisocial sexual behavior, criminal convictions leading to hospital admission included attempted murder, grievous bodily harm, actual bodily harm, and other more minor offenses. Two of these men had previous convictions for indecent assault, and 4 had convictions for assault, firearms offenses, robbery, and criminal damage.

Two of the 15 subjects used additional violence in the sexual attacks, over and above that involved in forcing the victim into the act.

Among the men offending after illness onset (N = 12), the mean time to sexual offense/behavior was 5 years, with a range of 1 to 25 years. Among the 3 who had offended sexually prior to illness onset, the sexual behavior had occurred up to 8 years previously. Three subjects (2 of whom had offended sexually prior to illness onset) had a history of other offending (2 of whom had a history of violent offending) some time (around 2 years) prior to illness onset. These offenses did not appear to have been committed in the context of features suggestive of the prodromal stage of schizophrenia, although such an assessment is always difficult.

The majority of patients (N = 12) appeared to be symptomatic at the time of the sexual offenses/behavior, representing a chronic state rather than deterioration associated with a more acute relapse. Although many (N = 14) could be said to be in contact with services, this contact appeared to be erratic, and missed appointments were not unusual. A minority (4 patients) were being prescribed medication at the time of the offense/behavior, and it appeared from the available records that compliance in these patients was poor.

According to contemporaneous reports, the sexual offending/behavior was considered to have occurred in the context of positive psychotic symptoms in 11 cases, while disinhibition was thought to be important in 13 cases. Ten men were suffering from persecutory delusions, while delusions of reference were less common and only 2 men experienced passivity phenomena. Only 1 had delusions of a grandiose nature. Auditory hallucinations at the time of the offense/behavior were common, occurring in 11 men, all of whom had also experienced command hallucinations. Delusions and hallucinations did not, other than in 1 case, appear to be directly linked in terms of content with offending behavior. The psychotic symptomatology described in the group at the time of the index offense/behavior was similar to that described in the larger study sample. One subject was reported to have taken illicit drugs, and 1 other to have ingested alcohol in the 24-hour period prior to the offense/behavior.

In terms of accommodation at time of index offense, 1 patient was living with family and 1 with a partner, while the others were living alone (N = 3) or in an institution (N = 10). Five were in regular contact with friends or family, while the remainder had lower levels of social support. There were no obvious changes for any of the patients in terms of social support in the period immediately prior to the offenses/behavior. These findings are in broad agreement with results from the larger study sample.

The victims of sexual offenses/behavior by this group of patients numbered 37 and were all female, one third of whom were adolescent, the rest adults. They were predominantly strangers (N = 22), although other victims included partners or immediate family (N = 3), members of the wider social network (N = 7), hospital staff (N = 4), and 1 hospital patient. This representation of victims was similar to their seriously violent but nonsexual offending male peers.

In terms of family background, 8 had experienced periods of at least 1 month's separation from their family. None had a known history of childhood sexual abuse (this is an area which is routinely explored during admission); however, 1 subject had been the victim in adult life of a serious sexual assault. Disturbances of family background included parental violence, neglect, and rejection (N = 3); significant parental conflict (N = 6); criminality within the immediate family (N = 3) (2 of whom committed violent and sexual offending); and a family history of mental illness (N = 6). Fourteen (93%) of the 15 patients in the group and the majority (71%, 39/55) of their seriously violent but nonsexual offending peers had experienced at least 1 of these factors. Behavioral problems during childhood included delinquency (N = 6), aggression (N = 4), school truancy (N = 5), and odd or solitary behavior (N = 8). Five had been referred to an educational psychologist. All patients in the group compared with just over two thirds (69%, 38/55) of the larger study sample

had evidence of at least 1 of these difficulties. Four of the sample had had psychiatric outpatient care at or before 17 years of age, although this tended to be sporadic, and 1 had required inpatient care. Although 6 subjects were considered to have failed at school, academically and socially, only 1 subject was considered during childhood to have learning difficulties. There was no difference between the groups in terms of socially isolated or withdrawn behavior during childhood.

None of the patients in the group of sexual offenders had a sexual relationship prior to 15 years of age, and none had a history of sexual promiscuity. Six patients reported never having had a sexual relationship, while the remaining 9 had had a limited number of sexual contacts (1 to 3). Four had a history of a stable relationship prior to the index offense, and 3 had children. At time of assessment, 3 described themselves as having a partner.

There were no significant differences between those with sexual offenses or antisocial sexual behavior and their seriously violent but nonsexual offending male peers in terms of overall severity of positive symptoms, thought disorder, or negative symptoms at time of research interview. BPRS scores, schizophrenia and depressive subscale scores of the CPRS,[33,34] and total SDAS scores were also similar between the 2 groups. Although overall negative symptom severity was similar between the 2 groups as measured by the SANS, there was a suggestion that those with sexual offenses or antisocial sexual behavior were less impaired in terms of sexual interest and activity than the larger study sample (60%, 9/15, with normal or only questionable impairment compared with 31%, 17/55, NS). Only 1 patient in the group of sexual offenders reported increased sexual interest. In addition, those with sexual offenses/behavior were more likely to describe subjectively the experience of an "inability to feel" (CPRS item 5) (40% [N = 6] compared with 11% [N = 6], Fisher exact test, p = .03), although there was no difference in severity of symptoms such as depressed mood or anxiety.

The Social Network Schedule was used to assess social contacts within the hospital. Although those with sexual offenses or antisocial sexual behavior identified a similar number of overall social contacts within the hospital as the larger study sample, they reported significantly fewer individuals they thought were friends (t value = 2.7, df = 49, p = .01). This finding was confirmed by fitting a negative binomial model to the number of friends (p = .03). There were no differences between the groups in terms of social support determined by visits from outside the hospital, which for both groups largely consisted of visits by family members.

Comparisons were made between patterns of cognitive functioning found in patients with sexual offenses or antisocial sexual behavior and the larger study sample. The group of sexual offenders as a whole was found to function at a poor average intellectual level, with a mean IQ of 87, and to show a range of cognitive abnormalities that have been described in association with a diagnosis of schizophrenia. There were no statistically significant differences found in the profiles of the 2 groups, either in terms of IQ or in the wide range of more specialized tasks, which included both parameters of response control and task approach.

DISCUSSION

Twenty-one percent of a sample of men with schizophrenia who were considered sufficiently dangerous to have commanded a special hospital bed had exhibited antisocial sexual behavior, but fewer than half of these had actually been convicted of a sexual offense. The selection process involved in special hospital admission as well as the small number of patients in the series limits the interpretation of the findings; however, there are indications that particular illness-related factors may be of relevance in this group of patients.

The patients in this study represent a severely and chronically ill group. In nearly all cases, sexual violence postdated illness onset, the average intervening period being approximately 5 years, with only 3 offending prior to illness onset. In addition, nearly all patients were suffering from psychotic symptoms at the time of the offense/behavior. These findings are similar to those reported in samples of patients with schizophrenia and a history of nonsexual violence.[3,5,6] The relationship between illness and offending in this group of patients, as with those described by Craissati and Hodes,[16] appears complex. Although positive symptoms did not directly relate to offending in most cases, such symptomatology occurs within the context of the personality damage, such as impairment of normal inhibitory controls, integral to schizophrenia.

The authors are not aware of any studies that have examined neuropsychological functioning of patients with both psychosis and sexual violence; however, neuropsychological impairment has been described among patients with a diagnosis of schizophrenia[35,36] and has been suggested as a factor that may contribute to sexual disinhibitory behavior.[37,38] The patients in this study were found to show neuropsychological impairments, which were consistent with nonforensic patients with schizophrenia, but no significant differences were found between patients with sexual offenses or antisocial sexual behavior and their seriously violent but nonsexual offending peers on a wide range of different tasks, including those thought to have a sensitivity to possible response disinhibition. Abracen and colleagues[39] have questioned findings of specific neuropsychological dysfunction in nonpsychotic patients with sexually driven offenses, and, in their study, patterns of disturbance appeared more influenced by the schizophrenic process.

At time of assessment, the patients with a history of sexual violence were twice as likely as the wider study sample to report unimpaired sexual interest. This finding may be of particular relevance in the context of impaired social and sexual functioning and a subjective awareness of emotional unresponsiveness. Characteristics of social networks within the hospital were assessed using the Social Network Schedule, an instrument that involves patient report rather than observation.[28] Results indicated that the patients with a history of sexual violence perceived themselves to have, and possibly did have, particular difficulties forming close relationships. Although such findings may have implications for understanding the sexual violence committed by these patients, since assessments were completed a considerable time after offending/behavior had occurred, it is possible that these findings represent consequences of behavior rather than being of etiologic importance.

Treatment of patients such as these is complex and necessarily involves not only treatment of positive psychotic symptoms but also individual and group work related to sexual issues, interpersonal relationships, more general social skills, anger management, and so on. Although many of the group were known to services at the time of the offense/behavior, contact was erratic, there was little evidence of comprehensive management, and, few, if any, were taking medication on a regular basis. This finding supports the view that most patients who act violently have not received adequate care or supervision[40] and highlights the need for comprehensive and vigorous treatment.

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See next page for Appendix 1.

Appendix 1. Checklist of Information Collected From Each Patient

- Demographic information
- Details of childhood experiences (up until the age of 17 years)
  - Environment in which the patient was raised
  - Family poverty
  - Parental loss
  - Early separation
  - Serious parental physical illness
  - Family history of criminality, alcohol or drug abuse or mental illness
  - Parental conflict
  - Parental rejection or neglect
  - Poor parental relationship with child
  - Parental violence or sexual abuse
  - Poor or inconsistent parenting
  - Developmental delay
  - Low IQ
  - Serious physical illness
  - Delinquency
  - Aggressive behavior
  - Early use of drugs or alcohol
  - School truancy
  - School failure
  - Childhood referral to an educational psychologist or psychiatrist
  - Social difficulties (including social isolation and peer rejection)
  - Psychosexual history
- Social history including social support and type of accommodation at time of index offense/behavior
- Illness course
  - Age at onset (taken as the date of first diagnosis of mental illness by a psychiatrist)
  - Nature of symptoms
  - Treatment received
- Details of criminal careers and previous violence
  - Information relating to mental state at time of offense/behavior
  - Victim category