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Do Sex Offenders Minimize Psychiatric Symptoms?

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ABSTRACT: With increasing frequency, forensic psychiatrists are called upon to evaluate sex offenders for the courts and criminal justice system. While many clinicians have observed that denial of paraphilia is common in sex offenders, few studies have examined whether this population has severe psychopathology other than paraphilia. Similarly, little is known about whether sex offenders minimize or deny symptoms of psychopathology when undergoing psychiatric evaluations. To study these questions, the authors administered the Minnesota Multiphasic Personality Inventory (MMPI) to 36 sex offenders, comparing the degree to which they minimized or denied psychopathology, dividing subjects along 2 dimensions: (*a*) whether they admitted to, or denied, paraphilia, and (*b*) whether or not they faced legal charges for sex offense. Results indicated that, first, patients who denied paraphilia were significantly more likely to minimize psychopathology than were those who admitted to paraphilia ($P < 0.05$); second, patients who faced no legal charges showed significantly more psychopathology than did those who faced charges ($P < 0.05$); and third, the most frequent forms of psychopathology were antisocial attitudes, depressive features, somatization, and thought disorder. These findings suggest that many sex offenders may experience, and deny, widespread and severe psychiatric symptoms in addition to their sexual disorders.

KEYWORDS: psychiatry, jurisprudence, criminal sex offenses

With increasing frequency, forensic psychiatrists are being called upon to evaluate male paraphilic patients who are alleged to have committed acts of sex offense [*1-3*]. There is widespread clinical agreement that denial of paraphilia is common in this population [*4,5*], but few studies have examined whether sex offenders manifest symptoms of severe psychopathology other than paraphilia [*6*], or whether they minimize such symptoms, when they are undergoing forensic psychiatric evaluations [*7*]. The current research investigates these questions by assessing the amount of minimization or defensiveness, and the types and severity of psychopathology, which are shown by a sample of alleged sex offenders who received a standardized battery of psychological tests as a routine part of their psychiatric evaluations.

Psychiatric evaluations of alleged sex offenders can originate from a variety of sources. For example, some patients are referred by the criminal justice system for pretrial assessments. The goal of this type of evaluation often is to provide information which can aid attorneys and judges in their approaches to a particular defendant. In other cases, patients may be self-referred, and may seek evaluation voluntarily as a first step toward obtaining treatment. The goal of this type of evaluation is to provide information which will be useful to the potential treating clinicians about the specific nature of the patient's paraphilia and about the patient's psychological strengths and weakness which may influence the course and success of treatment.

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Both types of evaluation described above attempt to provide information about whether or not the patient has a history of engaging in paraphilic behavior, and whether or not he demonstrates any current pattern of paraphilic sexual behavior or shows evidence of major psychopathology. However, the motivation of the paraphilic patient to be honest in revealing to the evaluating forensic psychiatrist various facets of his sexual behavior and psychological functioning may be influenced by a number of factors. For example, the patient who denies all allegations of having committed an act of sex offense may do so by making a categorical denial of all unusual experiences, including both unusual sexual and nonsexual experiences, such as symptoms of psychopathology. Similarly, the patient not facing formal legal charges of alleged sex offenses may be more motivated to deny aberrant experience to avoid possible prosecution than is the patient who is facing such legal charges.

Specifically, the current study has focused on the following research questions:

1. Do alleged sex offenders who deny engaging in paraphilic behaviors show more tendency to minimize psychopathology other than paraphilia than do alleged sex offenders who admit to engaging in paraphilic behaviors? Do patients in the former group show fewer signs of psychopathology than do those in the latter group?
2. Do alleged sex offenders who are facing no active legal charges at the time of their evaluations show more tendency to minimize, and fewer symptoms of psychopathology, than do alleged sex offenders who are facing active legal charges?
3. What kinds of psychopathology, other than paraphilia, are found most often in sex offenders?

Method

Subjects

The sample comprised 36 male patients who were assessed through psychiatric evaluations at the Sexual Behaviors Clinic, which is part of a university-based outpatient evaluation and treatment center associated with the Isaac Ray Center, Inc., Section on Psychiatry and the Law, Rush Presbyterian St. Luke's Medical Center and Rush Medical College in Chicago [*8–10*]. Of these 36 patients, 2 were alleged to have engaged in exhibitionism, 4 in incest, 6 in rape or attempted rape, 7 in heterosexual pedophilia, and 17 in homosexual pedophilia.

Patients ranged in age from 17 to 72 years, with a mean age of 36.4 years. They had completed a mean of 13.8 years of school (ranging from 8 to 21 years). Thirty-three (92%) were white, and three (8%) were black.

For the first series of analyses, the patient sample was divided into two groups consisting of those who did not admit to having engaged in paraphilic behavior ($N = 16$) and those who admitted to such behaviors ($N = 20$). There were no significant differences between these groups in age ($t = 0.12$, degrees of freedom [df] $= 34$, $P > 0.30$) or level of education ($t = 1.54$, df $= 34$, $P > 0.10$).

For the second series of analyses, the patient sample was divided into three groups: pretrial defendants who were facing formal legal charges of sex offenses ($N = 16$); individuals who were facing no formal legal charges ($N = 13$); and post-trial subjects who had already faced legal charges of sex offenses ($N = 7$) and had been adjudicated as Not Guilty by Reason of Insanity (NGRI). Again, there were no significant differences between these three groups in age ($F = 1.36$, df $= 2,33$, $P > 0.20$) or level of education ($F = 0.45$, df $= 2,33$, $P > 0.30$).

Procedure

The full 566-item Minnesota Multiphasic Personality Inventory (MMPI), presented in the standard booklet-form order [*11*], was administered by means of an interactive computer-

ized assessment system described in a previous report [*12*]. The MMPI validity scales used were those recommended by Greene [*13*] and also validated by Grow et al. [*14*] as being able to discriminate honest responders from experimental subjects instructed to minimize or exaggerate as well as clinical subjects expected to do so. These scales were also recently validated by the current investigators as being able to discriminate honest from invalid responders among criminal forensic patients [*15,16*]. These were the L, F, and K Scales [*13*], the F-minus-K Index [*17*], the Obvious-minus-Subtle Subscales or the difference between the sum of obvious and subtle T-scores [*18*], the Ds or Gough Dissimulation Scale [*19*], and the Mp or Positive Malingering Scale [*20*]. The Mp Scale is an empirically derived scale found to discriminate subjects instructed to minimize from honest responders. Thus, despite its name, the Mp Scale is designed to access minimization, not malingering.

Patients' test protocols were not used if their Test-Retest or Carelessness Scale scores exceeded five to exclude random responders [*21-23*]. This procedure helped to ensure that MMPI items were understood by all subjects.

Results

Comparison of Patients Who Deny Paraphilia with Those Who Admit Paraphilia

Table 1 presents the comparison of the validity scale scores of patients who did not admit to having engaged in paraphilic behaviors and those who did admit to such behavior. The results indicated that on all indices, the patients who denied paraphilia showed more evidence of minimizing psychopathology than did those who admitted to paraphilia. This difference between nonadmitters and admitters was statistically significant for six of the seven scales assessed, and the seventh scale produced a nonsignificant trend ($P = 0.092$) in the same direction.

Analyses of the clinical scales of the MMPI indicated that the nonadmitters showed less psychopathology consistently on all ten of the standard MMPI clinical scales, as would be expected, given the significant differences in degree of minimization found. These differences were significant ($P < 0.05$) on six of the ten scales (D, Pd, Mf, Pa, Sc, and Si).

TABLE 1—*Comparison of patients who deny paraphilia with those who admit to it.*

	Group		
Validity Scale[a]	Nonadmitters ($N = 16$), Mean	Admitters ($N = 20$), Mean	T-Test, T
MP Scale	54.8	45.0	2.47[b]
K Scale	18.2	12.4	2.74[c]
L Scale	55.8	49.6	1.74
F Scale	4.9	11.2	3.45[c]
F-Minus-K Index	−13.3	−1.2	3.48[d]
DS Scale	52.1	64.6	2.28[b]
Obvious-minus-Subtle Subscales	−34.0	52.8	2.96[c]

[a]For the MP, K, and L Scales, higher scores reflect more minimization. For all other scales, lower scores reflect more minimization.

[b]$P < 0.05$.

[c]$P < 0.01$.

[d]$P < 0.001$.

Comparison of Patients Facing Legal Charges with Those Not Facing Charges

The MMPI validity scale scores were also compared for patients who were facing active legal charges and those who were facing no charges or had already been found NGRI. There were no significant differences among those three patient groups on any of the seven validity scales assessed.

Table 2 presents the comparison of the MMPI clinical scales for those three patient groups. The results indicated that patients who were facing active legal charges showed less evidence of psychopathology on several MMPI clinical scales than did those who were facing no charges. This pattern was consistent across eight of the ten major MMPI clinical scales. Strong significant differences ($P < 0.01$) occurred on the scale sensitive to hysteria, somatization, and denial (Hy), and on the scale sensitive to symptoms of anxiety disorders (Pt). There was also a nearly significant tendency ($P = 0.057$) for this pattern to occur on the scale sensitive to suspiciousness (Pa), and a similar tendency ($P = 0.07$) on the scale sensitive to thought disorder and cognitive disorganization (Sc).

Clinical Characteristics of Sex Offenders

The following analyses present the clinical characteristics of the 24 paraphilic patients in the current study who showed no evidence of exaggerating on the MMPI. Minimizing protocols were included in these analyses, since elevations of clinical scale scores on these profiles as well as on valid profiles would be expected to reflect genuine psychopathology. The results indicated the following.

In this subsample of 24 patients, 10 (42%) had no clinical scales in the diagnostic range (T-score 70 or above). One third of this subsample had elevations in the diagnostic range on at least 3 scales, and over one fifth (21%) had such elevations on at least 5 scales.

The most frequent elevation above a T-score of 70 occurred in 38% of this subsample on the scale which primarily reflects authority conflicts and antisocial attitudes (Pd). The next most frequent clinical scale elevations above 70 occurred in 25% of this subsample on the scales which reflect depressive features (D), somatization and denial (Hy), traditional sex-role interests (Mf), and thought disorder and cognitive disorganization (Sc).

TABLE 2—*Comparison of MMPI clinical scales of patients facing charges with those not facing charges.*

	Group			
Clinical Scale	Charged ($N = 16$), Mean	Not Charged ($N = 13$), Mean	NGRI ($N = 7$), Mean	F
HS Scale	56.9	61.1	66.3	1.06
D Scale	63.7	71.3	71.3	1.14
HY Scale	57.6 (a)[a]	70.4 (b)	71.3 (b)	5.38[b]
PD Scale	70.1	73.6	78.6	1.21
MF Scale	66.2	73.8	65.4	2.74
PA Scale	60.4	71.6	75.0	3.13
PT Scale	59.4 (a)	75.5 (b)	74.4 (b)	5.47[b]
SC Scale	66.2	81.6	80.3	2.82
MA Scale	63.6	61.8	63.7	0.13
SI Scale	54.0	59.5	51.3	1.14

[a]Letters in parentheses indicate groups significantly different from each other.

[b]$P < 0.01$.

Discussion

The goal of the present research was to provide information helpful to forensic psychiatrists who must evaluate paraphilic patients, especially those who are defensive, and those in whom other psychopathology is also suspected. The study assessed paraphilic patients who were alleged to have committed acts of sex offense. The initial results suggest that within this group, patients who deny the allegations of paraphilia when undergoing psychiatric evaluation are also prone to minimize other symptoms of psychopathology. Thus the data indicated consistently across the seven validity indices that nonadmitters showed more defensiveness and less tendency to exaggerate when asked to provide self-reported descriptions of their psychological functioning and adaptation than do admitters. These data suggest that forensic psychiatrists should maintain extreme alertness to subtle signs of psychopathology when evaluating sex offenders who deny having engaged in paraphilic behavior, because these patients may be especially likely to minimize their reports of psychiatric symptoms in general.

The current data also indicate that patients who faced no legal charges were more likely to show symptoms of psychopathology other than paraphilia than were those who were facing active legal charges. Because there were no differences in minimization or exaggeration among the three patient groups, these factors could not have accounted for the present differences in clinical symptomatology. These results may be interpreted as having occurred in part because patients who seek psychiatric evaluation and intervention on a voluntary basis rather than because they are required to do so by the criminal justice system may be more psychiatrically disturbed in general, or more willing to talk to forensic psychiatrists about areas of psychological dysfunction as a way of asking for help with their paraphilia. An alternate interpretation is that patients facing no legal charges may constitute a group with a more diffuse symptom picture than is found in those who face legal charges. Patients facing charges may, in contrast, constitute a group whose primary psychiatric problems are those associated with paraphilia rather than other forms of psychopathology. Thus in the current sample, patients facing no charges who voluntarily sought psychiatric evaluation appeared to have more widespread and various psychiatric symptoms, including symptoms of hysteria, somatization, anxiety disorders, suspiciousness, and thought disorder or cognitive disorganization. Consistent with previous studies [*24,25*], the present data do not suggest any "typical" MMPI profile for sex offenders.

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