Paraphilia-related disorders and personality disorders in sexual homicide perpetrators

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Abstract

We investigated the relationship between paraphilias (PA), paraphilia-related disorders (PRD), and personality disorders retrospectively in a sample of 161 sexual murderers. Four groups were compared: (1) sexual murderers without a PA or a PRD diagnosis (n=47), (2) sexual murderers with at least one PRD but no PA (n=29), (3) murderers with at least one PA but no PRDs (n=29), and finally, (4) those with a combination of both (PA + PRD, n=56). The PA + PRD group showed a significantly higher prevalence for antisocial (42.9%) and sadistic (32.1%) personality disorders compared to the three other groups. Schizoid personality disorder was more often diagnosed in the two paraphilic diagnosed subgroups (PA = 24.1%; PA + PRD = 24.9%). Our data suggests that PRDs and personality disorders should be systematically assessed in sexual offenders, and that the combination of PAs and PRDs in sexual offenders may characterize a group who are more impulsive, consistent with personality disorders such as antisocial personality disorder.

Key words: sexual murder, paraphilia, paraphilia related disorder, personality disorder, sexual offender

Introduction

Kafka (1994) and Kafka and Hennen (1999) defined paraphilia-related disorders (PRDs) as characterized by "sexually arousing fantasies, urges or activities that are culturally sanctioned aspects of normative sexual arousal and activity that increase in frequency or intensity (for more than 6 months duration) so as to preclude or significantly interfere with the capacity for reciprocal affectionate activity". PRDs include compulsive masturbation, protracted promiscuity, dependency on pornography, cyber-sex or telephone-sex and severe sexual desire incompatibility. In contrast with paraphilias (PA) that are characterized by deviant sexual arousal, PRDs are characterized as disinhibited or excessive expressions of adult heterosexual or homosexual object choice that lead to clinically significant personal or interpersonal stress. PRDs can occur as distinct disorders or in comorbid relationship with PAs (Kafka and Hennen, 1999).

Kafka (2003) divided a group of 220 consecutively evaluated men into three subgroups on the basis of the lifetime cumulative number of PAs and PRDs. The total number of these disorders was considered as a measure of the severity of sexual impulsivity. The "high group" with at least 5 lifetime PAs and PRDs were predominantly sex offenders with multiple PAs who self-reported the highest rates of enacted sexual behaviors, the highest indices of current sexual preoccupation and the highest likelihood of incarceration for sex offences. These data suggest that when PRDs are included in the evaluation of sexual offenders, the men with the highest lifetime cumulative number of sexual impulsivity disorders (PAs + PRDs) may have a more "severe" condition.

In a study on 161 sexual murderers (Briken, Habermann, Kafka, Berner, & Hill, 2006) we examined whether a combination PAs and PRDs is a useful indicator that would be predictive of the severity of disturbance and possible risk of recidivism. Four groups were compared: men without a PA or a PRD (group abbreviation: no PRD, no PA) diagnosis, men with at least one PRD but no PA (group abbreviation: PRD), men with at least one PA but no PRD (group abbreviation: PA), and finally, those with a combination of both (group abbreviation: PA + PRD). The PA + PRD group showed more developmental problems, a higher persistent frequency of sexual activity, a higher number of previous sexual offences, more serial murders, more killing stranger victims, more sexual sadism and compulsive masturbation than the other groups. Thus, our findings were consistent with Kafka s report (2003) that, with the inclusion of PRDs as well as PAs, the cumulative lifetime number of sexual impulsivity disorders was a proxy measure of the severity of that domain.

In another study on the same population (Hill, Habermann, Berner, & Briken, 2006) we compared sexually sadistic with nonsadistic sexual murderers. Personality disorders in general were diagnosed more often in the sexual sadistic group. The two groups differed most in the prevalence of DSM-III sadistic personality disorder, a persistent pattern of general, non-sexual arousal and pleasure in humiliating, punishing and harming other persons. We also found higher rates of antisocial, borderline and schizotypal personality disorders among the sexual sadist group.

There has been no study systematically investigating the relationship between PAs, PRDs and personality disorders in either sexual offenders or, specifically, in sexual homicide perpetrators. The aim of this study was to investigate whether sexual murderers with a combination of PAs and PRDs have a higher prevalence of those personality disorders that may increase the risk to reoffend, namely antisocial (Hanson & Morton-Bourgon, 2005) and sadistic personality disorders (Berger, Berner, Bolterauer, Gutierrez, & Berger, 1999).

Method

More detailed information about the methods and data describing the influence of brain abnormalities (Briken, Habermann, Berner, & Hill, 2005), sexual sadism (Hill et al., 2006), PRDs (Briken et al., 2006), and a comparison between single and multiple murderers (Hill, Habermann, Berner, & Briken, 2007) in this series of sexual murders has previously been published. We evaluated psychiatric court reports on 166 men who had committed sexual homicide. In five cases we had missing data according to the PRD diagnoses, so we excluded these records. The reports were requested mainly to assess criminal responsibility or for risk assessment prior to release or changes in security levels of imprisonment. They were based on external information (attorney, court, witnesses, relatives, former psychiatric and psychological assessments), the psychiatric examination as well as somatic and psychological assessments. Additional information was evaluated if available (psychological tests, previous forensic reports, court verdicts etc.).

PAs were diagnosed by the raters according to DSM-IV (American Psychiatric Association, 1994). PRDs were defined according to the criteria described by Kafka and Hennen (1999) as mentioned above because there is no DSM-IV diagnosis for PRDs or specific criteria for similar diagnostic categories like sexual addiction. We adopted the definition of sexual homicide by Ressler, Burgess, and Douglas (1988). Socio-demographic data, childhood development, sexual, psychiatric and criminal history were assessed with an operationalized, computerized questionnaire and were reported in detail elsewhere (Briken et al. 2006).

Interrater reliability was assessed evaluating 20 reports by all three raters (PB, AH, NH) and obtaining a consensus rating for each item. Kappa coefficient scores > 0.40 were deemed

sufficiently reliable to report. For paraphilias the mean Kappa coefficient was = 0.82. For PRD diagnoses interrater reliability was = 0.91 for compulsive masturbation, = 0.67 for protracted promiscuity, = 0.73 for pornography dependence, and = 0.78 for severe sexual desire incompatibility. The interrater reliability was =0.64 for avoidant, =0.46 for schizotypal, =0.71 for schizoid, =0.64 for antisocial personality disorder, and =0.61 for sadistic personality disorder (according to DSM-III-R; American Psychiatric Association, 1987). For this study we excluded other personality disorders because of low kappa values.

Statistical Analysis

Between-group comparisons were analyzed using the Kruskal Wallis test for nonparametric categorical variables. Statistical significance was set at p<. 05. For statistical analysis SPSS 11.5 (SPSS Inc., Chicago, 2003) was used.

Results

The specific PA and PRD diagnoses from this sample are listed in table 1 and were previously published elsewhere (Briken et al., 2006).

Table 1: Lifetime prevalence of paraphilias and paraphilia related disorders in a group of 161 sexual murderers (from Briken et al., 2006)

variable	NoPRD, noPA		PRD		PA		PA+PRD	
	N	%	N	%	N	%	N	%
subgroup	47	100	29	100	29	100	56	100
DSM-IV paraphilias								
Sexual sadism[f]	0	0	0	0	14	48.3	46	82.1
Masochism	0	0	0	0	3	10.3	6	10.7
Pedophilia	0	0	0	0	10	34.5	11	19.6
Transvestic fetishism	0	0	0	0	4	13.8	6	10.7
Fetishism	0	0	0	0	3	10.3	2	3.6
Exhibitionism	0	0	0	0	1	3.4	5	8.9
Voyeurism	0	0	0	0	2	6.9	8	14.3
Paraphilia NOS	0	0	0	0	3	10.3	10	17.9
Paraphilia related disorders (PRDs)								
Compulsive masturbation[e]	0	0	6	20.7	0	0	42	75.0
Promiscuity[e]	0	0	26	89.7	0	0	27	48.2
Pornography/ telephone sex dependence[e]	0	0	0	0	0	0	11	19.6
Severe desire incompatibility	0	0	4	13.8	0	0	12	21.4

Mean number of sexual impulsivity disorders (SD)[e,f]	0	0	1.3	0.5	1.4	0.6	3.2	1.2

[a] NoPRD, noPA vs. PRD group differences statistically significant (p< 0.05)
[b] NoPRD, noPA vs. PA group differences statistically significant (p< 0.05)
[c] NoPRD, noPA vs. PA + PRD group differences statistically significant (p< 0.05)
[d] PRD vs. PA group differences statistically significant (p< 0.05)
[e] PRD vs. PRD + PA group differences statistically significant (p< 0.05)
[f] PA vs. PRD + PA group differences statistically significant (p< 0.05)

We found a significantly higher prevalence for antisocial (42.9%) and sadistic (32.1%) personality disorders in the PA + PRD group compared to the three other groups. Schizoid personality disorder was more often diagnosed in the two paraphilic subgroups (PA = 24.1%; PA + PRD = 24.9%).

Table 2: Prevalence of personality disorders in a group of 161 sexual murderers

variable	NoPRD, noPA		PRD		PA		PA+PRD	
	N	%	N	%	N	%	N	%
subgroup	47	100	29	100	29	100	56	100
DSM-IV personality disorders								
Avoidant	8	17	2	6.9	4	1.8	6	10.7
Schizotypal	0	0	0	0	0	0	3	5.4
Schizoid*	6	12.8	1	3.4	7	24.1	12	21.4
Antisocial**	7	14.9	8	27.6	5	17.2	24	42.9
Sadistic (According to DSM-III-R)***	1	2.1	4	13.8	6	20.7	18	32.1
Kruskal Wallis test: * p<0.1; **p=0.01; ***p=0.001								

Discussion

In our previous study (Briken et al. 2006) on the same population, membership in the PA + PRD group was associated with sexual sadism, serial murders, killing stranger victims, committing previous sexual offences and having spent the most time incarcerated. Further investigating the four groups, our hypothesis to find the highest prevalence of antisocial and sadistic personality disorders in sexual murderers with PA + PRD group was confirmed. The prevalence of personality disorders reported here is consistent with other studies on paraphilic and non-paraphilic sexual offenders (Dunsieth et al. 2004; Leue, Borchard, & Hoyer, 2004). Studies that compared paraphilic with non-paraphilic sexual offenders reported an association of PAs with avoidant or cluster C personality disorders. In this report, the prevalence of schizoid personality disorders was higher in the two paraphilic subgroups. This is in accordance with Stones' (2001) study on biographies of serial murderers and may reflect the emotional loneliness as described by Milsom, Beech, and Webster (2003). Milsom et al. (2003) found that sexual murderers, compared to rapists, reported significantly higher levels of grievance towards females in childhood, significantly higher levels of

peer group loneliness in adolescence, and significantly higher levels of "self as victim" in adulthood. Paraphilic fantasies in these men may develop to cope with avoidance of or severe anxiety associated with interpersonal intimacy.

There are no prior studies that specifically investigated the relationship between PRDs and personality disorders in sexual offenders. In contrast with men with only PAs, our study shows that sexual murderers with both PAs and PRDs are more impulsive as characterized both by their diversity of criminal activities and sexual impulsivity in association with sadistic and antisocial personality disorders. Thus, we would speculate that in the PRD + PA group we might find several pathways (according to Ward and Siegerts pathway model; Ward, Polaschek, & Beech, 2006) that may lead to sexual offending: intimacy deficits, deviant sexual scripts, emotional dysregulation, generalized impulsivity and antisociality. While deviant sexual scripts characterize PAs, it seems to be that the combination of PAs with additional non-socially deviant forms of sexual impulsivity (PRDs) is associated with indices of more pervasive behavioural disinhibition.

In our earlier study (Briken et al. 2006) a history of sexual abuse, higher PCL-R (Hare, 1991) scores, alcohol dependence and consumption of alcohol during the index offense were highest in the PRD-only group where protracted promiscuity was the most commonly diagnosed PRD. Sexual offending in this group seems to be less driven by deviant sexual scripts but more by emotional dysregulation, narcissistic and antisocial traits, a more manipulative, extroverted style with sexualized relationships.

Our study underlines the relevance of a differentiated and detailed diagnostic evaluation in sexual offenders not only for axis I but also for axis II disorders. For comprehensive personality assessment a structured instrument such as the Structured Clinical Interview for DSM-IV (part 2: personality disorders; SKID-II; First, Spitzer, Gibbon, William & Benjamin, 1997) should be used. Conversely, when personality disorders are systematically diagnosed in sexual offenders, PRDs as well as PAs may also be present and should be systematically included in sexual offender evaluations. Consistent with Kafka s observations (2003) the presence of multiple sexual impulsivity disorders in sexual offenders (multiple lifetime PAs + PRDs) is associated with indices of increased severity, including sadistic and antisocial personality disorder.that may also be associated with a higher risk for recidivism.

There are several limitations associated with this study s methodology. The primary limitation is that this was a retrospective study based on forensic reports. Despite the length and detail afforded in these reports, they were not written uniformly and the inter-rater reliability of the reporters could not be ascertained. Because of this limitation, it is possible that differences in methods of inquiry to assess quantitatively specific personality disorders, paraphilic and, especially PRDs, may not have been uniformly determined. Despite this limitation, this is the largest sample of sexual murders systematically evaluated and reported in the current forensic literature.

To our knowledge this study is the first to find a relationship between PRDs, PAs and personality disorders in the research on sexual homicide perpetrators. The study would have been enhanced were we able to identify a control group of non-sexual homicide perpetrators or non-homicidal sexual offenders for comparison. Our data suggests that PRDs (or similar conditions like hypersexual disorder or sexual addiction; Kafka, 2010; Marshall & Briken, 2010) and personality disorders should be systematically assessed in sexual offenders and that the inclusion of nonparaphilic sexual impulsivity disorders in our evaluation procedures may help to more readily identify those offenders with a more aggressive, progressive and recidivistic course. They also indicate that sadistic personality disorder, although dropped from DSM-IV because of its low prevalence is still important to consider in men who commit sexual violence.

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Footnote

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