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PSYCHIATRIC EXAMINATION OF THE SEXUAL PSYCHOPATH*

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The following article is a companion to one entitled "The Psychiatric Examination," which appeared in Volume 54 of this *Journal* at page 431, in 1963. Observing that the psychiatrist's opinion in a case involving a charge of sexual psychopathy is of utmost importance to both the defendant and society, Dr. Meyers discusses the problems presented in an attempt to make a diagnosis and the procedures he considers most fruitful in examining the individual suspected of being a sexual psychopath.—EDITOR.

A continuing and somewhat disturbing problem in medico-legal matters is the accurate determination of sexual psychopathy. It is surprising that more insistence upon accuracy does not prevail when it concerns the lives of those involved to such a major degree. A label of sexual psychopathy carries with it an immediate penalty which may take freedom from the individual for periods varying from months to a lifetime and in addition place a social stigma that possibly may never be removed. It is a process that is easy to impose, but very difficult to erase. A dire responsibility rests upon those entrusted to render opinions in this area, for an error will either continue a threat to society or deprive the accused of his way of life. Laws were made to accomplish a purpose, to protect society from those who are hazards or potentially so. Sexual psychopathy laws are designed to cope with a difficult situation and are intended to be fair, as well as supply the protection needed. It is generally recognized that when an individual appears repeatedly before the court charged with the same type of offense that he will continue to return unless something is done to restrain him or to change his pattern of behavior. An opinion by an expert in such cases is relatively easy, for the behavior pattern speaks for itself. Unfortunately, too much reliance is placed upon the record of the case, and not enough on the actual examination data. Examiners will often state frankly that they know no positive criteria of sexual psychopathy except a history of repeated abnormal sexual acts. Many examinees, however, are examined after their first offense and all too often a diagnosis is made on the basis of a single act, and little else. The hard fact is that there are no pathognomonic signs of sexual deviation other than the behavioral background. The record per se, to be conclusive evidence, must be more than a repeated act, for the matter of coincidence must be ruled out. Circumstances may condition a seemingly abnormal act, which is not necessarily a result of pathology.

Despite the lack of pathognomonity, a rather positive appraisal may be made in a majority of cases by the clarification of the patient's personality pattern. This is a process that varies with the approach of the examiner, his skill in sensing the personality values under the surface, and his ability to elicit reliable reactions on the part of the patient.[1]

This uncertainty about how a diagnosis is, or even can be, made is overlooked in laws that relate to the control of sexual offenders. Even

* This paper was presented by the author before the International Conference on Medical Correction in Vienna, Austria, on October 30, 1963.

[1] See Meyers, *The Psychiatric Examination*, 54 J. CRIM. L., C. & P.S. 431 (1963), which is a companion presentation to this article. The principles and methods discussed in the former apply in this study as well.

though examination skill is not a uniform part of the armamentarium of psychiatrists, and many psychiatrists are really not adept in this area, the law will accept the opinion of the psychiatrist, almost in blind faith. The only protection built into these laws is that more than one report is usually called for. The only real challenge to the expert's opinion is another opinion, so that decisions all too frequently become a matter of numbers, that is, two or three out of three opinions clinches it. The quality of these opinions becomes a secondary matter—the presumption is that all psychiatrists have equal weight.

In examining a defendant general areas of psychiatric inquiry are rather broadly followed by most examiners, especially when psychotic and medical appraisals are involved. When the examinee's general personality structure is under study the individuality of the examiner inevitably enters into the process. Two general areas of information prevail. One is reliance upon verbal and narrative data—obtained from the patient—and corroborated by others who are related in some way to him. The other is in the use of projective, or inferential data, which is secured by means of tests, observed behavior, or actual test performance. A third area of information is that obtained by objective devices such as the polygraph, but this is another facet of patient narrative disclosure, or confirmation of it.

The narrative of the patient cannot be given a blanket acceptance, but rather a note of questioning doubt should be maintained throughout. This is especially true when the patient is under legal restraint or under great emotional tension, or if he is facing an impending penalty if his guilt is established. Even the cooperative case is a victim of unconscious distortions of truth. A lack of reliability in the narrative is attributable to the need of the patient to protect and maintain support for his ego. This latter is probably responsible for more distortion in truth than actual fear of the penalty. It is a good practice to estimate the degree of veracity that can be expected of an examinee. An element of skepticism will cause fewer errors than a literal acceptance of the patient's statements. If belief is carried too far the examiner can be thrown off the track of an objective appraisal, and he may find himself defending the patient and espousing his cause.

The sexual psychopath, or the mentally disordered sexual offender as he is currently termed in California, is defined by statute rather than by clinical study. Illinois and Michigan established the "sexual psychopathic personality" as having (1) a mental disorder amounting neither to insanity nor to feeble-mindedness; (2) a mental disorder that must have existed for a period of a year; (3) exhibited propensities for the commission of sex offenses.[2] Along with this definition the current criteria in California should be considered:

> "As used in this chapter, sexual psychopathy means any person who is affected in a form predisposing to the commission of sexual offenses, and in a degree constituting a menace to the health and safety of others, with any of the following conditions: a) Mental disease or disorder; b) psychopathic personality; c) marked departure from normality.[3]
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> ". . . It is easy to be affirmative where, for instance, there is a wide difference of ages with or without violence or where violence is involved regardless of age."[4]

In this same connection Ellis and Brancale present a rather detailed classification of offenders, in terms of the nature of the act committed and the age of the child involved.[5]

From these references and others the gist of the definition of the sexual psychopath sums up to an individual, who: (1) because of an involvement or deficiency of the mind, is prone to the commission of sexual acts that are considered at variance from the practices of conventional society in which he lives; (2) commits acts which may be, and are often consistently, a hazard to the health and safety of those on or against whom they are committed; (3) chooses, either willingly or unwillingly, as partners for his acts subjects of either sex who are under the age of 14.

The examination of this group of patients must pinpoint a clarification of these points, if it is to assist in the adjudication of the individual. It is this determination that is the subject of discussion in this paper.

A psychiatric examination is concerned with facts. These facts may not be explicitly stated and are not always clearly presented for inspection; rather they are more frequently hidden behind a façade of personal defenses. The examination is a

[2] DRUMMOND, THE SEX PARADOX 49 (1953).

[3] Liest, *California's Sexual Psychopath Law: Its Medico-Legalities*, 9 CORRECTIVE PSYCHIATRY 1, 4 (1963).

[4] *Id.* at 10.

[5] ELLIS & BRANCOLE, THE PSYCHOLOGY OF SEX OFFENDERS 14–21 (1956).

procedure concerned with the values of the patient, with his patterns and way of behaving. It is interested in truth, but more than this, in whether the patient is telling the truth. Considerable advantage attends the efforts of the examiner who can give a correct rating as to the degree of veracity that can be applied to the patient's statements. The level of truth could be about the same in all sectors of the examination data. There are various ways in which an assessment of veracity can be made, the easiest of which is use of the sensitivity of the experienced examiner. An ordinary clinical inquiry, if made under reasonably favorable circumstances and not hurried, will bring to light many discrepancies and show in rather clear relief a pattern of falsification. An aid in this evaluation is to watch some index of tension during the procedure. This may be a change in the tempo of response, a restlessness, perspiration on the head or clothing, flushing of the face, changes in the eyes, and also a change in the rate and depth of the respiratory movements. A surer method, of course, would be to attach the patient to a recording device such as a polygraph, or even a simple skin resistance detector.

A comparison of information given by the patient and that determined from other sources is helpful. This comparison, together with an estimate of the patient's veracity, serves to place him properly in relation to the facts. It also helps to outline his defense façade, which can be expected to be part of his responses in all work done with him. On this basis an investigation of the compulsive factor which is nearly always present in these cases may be undertaken. Practically all sexual problems have a strong compulsive factor behind them. The willingness or ability to control it is often the crux of the matter of predictability of the case.

The degree of compulsion present in the patient can be estimated by contrasting the amount of the tension observed and the superficial appearance of tranquility. Tension can be detected by gross and fine movements of the patient, the pressure exerted in handwriting, the response to startle stimuli, and of course by means of psychological testing. Closely related to the level of tension is the patient's potential for control of it. When controls are good, tension does not represent a problem for the patient, but when the controls become shaky tension will break through in the form of the established behavior pattern.

Controls, if they break, usually do so when emotional pressure or stress is exerted upon the individual. It is quite important that this factor be determined. Sexual problems in the great majority of cases represent the possession of poor controls. Control is estimated by test situations, not only in psychological tests, but also by the effects in the consultation room of imaged situations similar to real life settings that incorporate stress. Some skill is required properly to stage the details so that the patient will react as he would in the actual situation. Observation by the examiner is of course for his own information. Should confirmation of his conclusions be required, instrumentation would be necessary.

Evaluation of tension and the stability of controls is conditioned upon the individual case and again will require use of the experience of the examiner. The psychopath with a calloused surface will not give as much information as the sensitive, emotionally labile person. Also, the asocial childish personality type, the individual who has no appreciation of the significance of falsification, will be resistant. A third type of resistant case will be the pathological liar.[6] These exceptions represent a small percentage of sexual offenders coming to examination. Here, also, the trained examiner will detect the nature of the personality with which he is dealing.

Determination of the pattern of sexual behavior is often simplified by the arrest record of the case. This, however, is not sufficient for a positive diagnosis. There should be demonstrable data showing psychopathology confirming such behavior. Psychological testing is helpful in supplying clues, but often is sterile in puzzling cases. Again, by use of tension studies it is possible to outline the areas of neurosis in many cases.

Examinations using the techniques of tension study are best performed with the patient in the reclining position. Here the changes in movements of the thorax are more easily observed. Care must be taken that stimulated tension will relax before another exciting situation is presented to the patient. When skilfully performed the pattern of the problem will be outlined to a surprising degree. The work of Wolpe gives the basis for this procedure.[7] While the average examination procedure will not use specialized methods such as these, there

[6] Floch, *Limitations of the Lie Detector*, 40 J. CRIM. L., C. & P.S. 651 (1950).

[7] WOLPE, PSYCHOTHERAPY BY RECIPROCAL INHIBITION (1958).

are cases in which a detailed, true picture is of vital importance. Even with resistant cases much help can be obtained by this approach.

Once the pattern of the neurosis, i.e., the nature of the sexual impulses of the patient, seems obvious, the information learned should be presented to the patient, giving him an opportunity to deny, confirm, or elaborate on the picture presented. When the patient persistently denies the details, even the arrest record, a conclusion must be drawn on the basis of deduction. For example, the pattern of sexual behavior given by the patient should fit his living situation. Any excess in the way of morality or immorality should be questioned. A denial of guilt is often overbalanced by denial of any irregularity in the sexual life of the individual. The details of the examinee's usual marital sexual practices are helpful in posing questions about the overall values of our patient. Arrests for other charges may be of help in estimating the sense of responsibility present. But perhaps most revealing in resistant cases are disclosures about their feelings about women. Pedophiles, for example, have marked disturbances in their concepts of the heterosexual roles of both men and women. In many of them there is an inability to discern the real feminine position in our culture. They also have a distorted idea of mature femininity.

Potential violence is detectable on examination by first suspecting it, and then by judicious use of psychological tests, especially in the use of the TAT pictures and in tests using color. Sexual violence occurs with sexual arousal. It would be most unusual for this to be limited to the one or two instances in the record of the case. In some way the sexual life of the patient will reveal a suggestion of a drive that will be beyond his control. The potential harm may stem from frustration and not from an actual sexual approach. This facet will be detectable in some area of the patient's life in most cases. Or it may show up in fantasies or dreams. It is conceivable that a benign clinical and test picture may be given by an incipiently violent case, but it is not apt to be so—some sign of the buried force will be revealed. Any clue suggesting possessiveness or jealousy must be followed through and its ramifications explored.

An important area offering much potential information is that of masturbation. Any continuation of the practice beyond the adolescent years should be investigated in detail, especially if it accompanies an active marital sexual life. Masturbation when heterosexual outlets are available suggests either undue preoccupation with sex, an unusually strong sexual drive, or an active schizophrenic process.

Schizoid personalities as well as actual schizophrenics, when associated with sexual irregularities, must be viewed with concern and regarded as serious problems. Certainly, at best, they should be subjected to a more prolonged observational study, and the possible direction of outbursts identified.

With the development of the inquiry into the nature of our patient's problem, the importance of unfolding a picture of his self image becomes clearer. What one views as his self concept incorporates a sum of his values and his place in the social scheme of things. Camilla Anderson has given a concept of the self image that is practical and understandable:

> "Whenever the *structure* of the psychological self-image is broken or threatened, the anxiety felt is known as guilt. Since the structure is composed of many traits demanded by the significant people, there is attached a value to each one which is that of 'good' or 'right'. The nature of the trait is of little consequence but only the acceptability of the trait to the significant people. It may be inadequacy, dependency, sexual infantalism, or some hostility that is structuralized; but it took place out of necessity (having these traits made the significant people feel more comfortable), and the trait is highly regarded morally. To break one's structure, therefore, implies breaking one's moral code, and the result will be a feeling of guilt.
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> "Whenever the anticipated function of the psychological self-image is disturbed, the anxiety feeling aroused thereby is felt as frustrated entitlement or outraged virtue. Since the use of any character trait implies some conceived virtue in action, it is clear that if it does not bring about the anticipated response from the other person, or get the 'correct' functional results, the disturbed feeling that is generated in the individual will be that he is the innocent victim of a neurological assault.
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> ". . . The whole fabric of our culture is morally rather than practically oriented. . . . According to my observation and the theory presented here, rage, resentment, hostility, or the destructive impulse is not an innate characteristic of man,

but is always and invariably a reaction to a sense of anxiety.

"The self-image can best be clarified through examination into those areas where one finds rage, resentment, withdrawal or paralysis phenomena, conversion symptoms, sense of entitlement, felt needs, or unavailable assumptions (things taken for granted) in regard to the self or other people."[8]

The self-image of the sexual offender incorporates the pattern of the acts to which he is habituated. Sometimes this is included in a rather literal form, and a preference for children as sexual objects, for example, will be revealed in other productions. There will be significant Draw-A-Person test protocols, an interest in situations and values common to children, a proneness to be drawn to places where children gather. Many homosexual pedophiles are very active in the Boy Scout movement. Others serve as counselors in camps and schools, and still others attract children by activities and possessions of interest to them. In many homosexuals the rule is that there is an absence of the feminine, or a reduction in the intrusion or depth of it into the individual's life.

How about the old man who molests little girls? What self-image can be present that would identify this process?

Two general groups of old men who molest little girls are identifiable. One is the case of constant association with a single girl—a daughter, boarder, relative—who often, in an unchildish way, acts seductively and lures the old man, often an affectionate, sensuously starved, and lonely individual, into intimate sexual acts. Then on the other hand there is the case of the old man who entices children indiscriminately into secretive places where he sexually handles them. There is a difference in the two, especially in the degree in which they may be considered a hazard. As a rule the former case is frank, remorseful, and hurt. He does not show the devastations in his personality structure found in the latter case. In the second instance there will be a decline in his cultural veneer and evidence of the organic nature of his act will show. Test data will reveal this organicity, and with it an immature child-like interpersonal scale of values. He is apt to deny his guilt, even in the face of indisputable evidence. The sexual acts here are not products of passion, rather they are entitlements of the old man's false self-image.

When the molester of little boys is a young man, he is usually a homosexual who selects children. They are usually fellationists, though there are many who seem to wish mutual handling of the penis. Dangerous cases are the sodomists with strong drives. The anamneses of these cases are rather characteristic and will soon show the outline of the problem.

The polymorphous perverse case, or the offender who selects either boys or girls, is usually schizophrenic. His acts are as distorted and bizarre as his mind. Selection of infants or very young children is an act of this group. Values are bizarre and twisted. Examination data show this distortion without much difficulty.

In this study, some principles are presented. There are guides that help to highlight abnormalities and to bring the problem to the surface. For example, the principle that every excess implies a defect, is very valuable in pointing out areas needing inquiry. Another rule, the mind pleads guilty to a lesser crime to hide a greater, is surprisingly a frequent maneuver. Admission of guilt in some unrelated area should arouse suspicion about what is not admitted.

Here is presented a plan for the examination of the sexual psychopath that will help the experienced examiner uncover the picture of sexual psychopathy. Suggestions for evaluation of the degree of veracity, compulsion, and potential violence are given. A short reference to the use of the self-image is given. Finally two rules of the mind are mentioned, and their uses as aids to the examiner are pointed out.

[8] Anderson, *The Self Image: A Theory of the Dynamics of Behavior*, 36 MENTAL HYGIENE 227 (1952).