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SEX OFFENDERS IN CROATIA: FIFTEEN YEARS LATER

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SUMMARY

***Background**: The aim of the study was to compare the characteristics of sex offenders today, and those who committed a sex crime fifteen years ago, in regard to their psychiatric-forensic aspects.*

***Subjects and methods**: Data from the University psychiatric hospital Vrapče, Center for forensic psychiatry on court people sent for psychiatric and forensic evaluation, who were accused of sex offense in two time frames (1998-2001 and 2010-2016) were analysed. In total there were 50 and 57 male subjects sent for an evaluation.*

***Results**: In both groups rape was the most prevalent offence, and both groups had the same prevalence of abuse, earlier psychiatric treatment and the majority of offenders were diagnosed with dissocial personality disorder and other personality disorders. Paedophilia was diagnosed in only a minority (14% and 7% respectively) of cases. The latter group (2010-2016) committed more sex offences against children, more often were with no mental disorder and less often had alcohol dependence and mental retardation. Up to one third of the later group were not giving their defence, compared to 4% of the former group.*

***Conclusions**: Changes in court case law and psychiatrists' usage of diagnostic criteria have influenced the prevalent diagnoses in sex offenders. Paraphilias are not often diagnosed in sex offenders because they do not confirm the act, and in recent years more often use not to give their defence (which makes reaching the diagnosis more challenging).*

***Key words:** forensic psychiatry - sex offenders - criminal responsibility - paedophilia*

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INTRODUCTION

Sexual delinquency is a complex phenomenon, defined as any sexual act forced upon a person who did not give his or her consent (Miller et al. 1988). It can be viewed from two different perspectives, both of which raise much of the heated debate among the lay population. On the one hand, sexuality (both normal and pathological) is an emotion-rising topic that produces intense emotional reactions on the individual, familial and societal level. On the other hand, delinquency (and especially murders and sex offences) are another topic that induces individual, societal and political debate. Also, the high re-offending rates are additional reason for concern (Lindsay et al. 2004). Research into sexual delinquency and sexual offenders in Croatia is sparse (Goreta et al. 2004).

Sex offenders comprise 12% of all inmates in prisons (Peugh & Belenko 2001). Contrary to public beliefs that sexual offenders are mentally disturbed people with severe mental disorders, only the small minority of sex offenders are nonguilty by the reason of insanity (6.5-21%) (Peugh & Belenko 2001, Novak et al. 2007). Although the majority of sex offenders do have some mental disorders, these are not disorders that affect person's mental capacity to understand his/her acts, but personality disorders, substance abuse disorders and paraphilias (Kanyanya et al. 2007). Psychotic disorders are rare (2-4%) (Miller et al. 1998, Peugh & Belenko 2001, Valenca et al. 2015). Among personality disorders, the most frequently present is antisocial personality disorder (similarly to other offenders) (Miller et al. 1998, Koch et al. 2011, Hoertel et al. 2012).

Alcohol can play a role in the offence, both in offenders who have a mental disorder related to alcohol (abuse or dependence), and in offenders who do not have a mental disorder related to alcohol, but were nevertheless drunk at the time of the offence (Hoertel et al. 2012). More than a half of the perpetrators had at least some degree of alcohol in their blood at the time of the offence (homicidal sex offenders more often than nonhomicidal, those who committed offences against boys more often than those who committed against girls) (Koch et al. 2011, Kim et al. 2017, Looman et al. 2004). Drug use is also often associated with sexual offences, more often with the victimization of adults than of children (Ahmmeyer et al. 2003).

Some people who have a mental disorder can have diminished or absent criminal responsibility due to the influence of the mental disorder onto their capacity to understand and/or control their actions (Valenca et al. 2015). The absent capacity is usually associated with psychotic disorders. There are four levels of criminal capacity/responsibility recognized by the Croatian criminal law: full responsibility (which is a default state in every adult person), diminished responsibility,

diminished responsibility to a greater degree and absent responsibility (not guilty for the reason of insanity, NGRI). The person who is NGRI (criminally irresponsible) cannot be punished (as s/he is not guilty) and, if there is a risk of committing a new offence in future, is committed to involuntary inpatient treatment in a forensic mental hospital or is sent for outpatient psychiatric treatment. Offenders who are of diminished responsibility are still punished (as they still have a certain degree of responsibility), but can be also sent for a psychiatric treatment (in case of a psychiatric disorder that was influential to the offence) or for a treatment of a drug dependence (if there is a psychoactive substance /including alcohol/ dependence and this dependence significantly influenced the offence). It is important to note that the criminal responsibility is not a stable characteristic of a person (the person him- or herself is not criminally responsible for the rest of the time), but it is related to the one offence, and only to the time of the offence (tempore criminis).

Goreta et al. researched the forensic-psychiatric aspects of sexual delinquents sent for the psychiatric evaluation to the Centre for forensic psychiatry of the University psychiatric hospital Vrapče in the 1998 - 2001 time frame (Goreta et al. 2004). During that time 50 sex offenders were sent for an evaluation. Not every single sex offender (nor other offender) is sent for a psychiatric evaluation, but only those for whom any party in the court (the judge, the prosecutor, the defence, the defendant himself) suspects that might have a mental disorder that could have influenced the behaviour of the offender at the time of the offence.

Since there have been no more studies into the characteristics of sex offenders in Croatia in regard to their psychiatric-forensic aspects, and given the importance of these studies for planning prevention, treatment and lowering the re-offending, the aim of this study was to compare the characteristics of sex offenders in 1998-2001 research and sex offenders fifteen years later.

SUBJECTS AND METHODS

The data were collected from the University Hospital Vrapče, Center for forensic psychiatry, on people sent for psychiatric and forensic evaluation, who were accused of sex offences in time period 2013-2016 (fifteen years after the initial research). But, due to the fact that significantly less people were sent at the same time period (four years), it was decided to expand the time frame to 2010-2016 (and thus the groups were of similar size: 50 and 57). One of these subjects was female, so she was excluded from further comparisons (therefore the comparison samples were 50 and 56 male subjects).

The investigators collected the data from written evaluations from the Centre for forensic psychiatry. The procedure of the evaluation of every subject is the following: one of the forensic psychiatrists from the hospital makes the evaluation after several interviews with the person sent for evaluation (and if necessary, after observation of the behaviour of the person at the ward). This evaluation is always supplemented by a psychological evaluation and basic blood tests. If the condition of the person asks for, other investigative procedures are used, such as EEG, additional laboratory findings, X ray, neurological examination. Every single subject, after these investigations and interviews, is presented at the official meeting. All the psychiatrists, psychiatry trainees and psychologists from the hospital are invited to this meeting, and usually there are 10-20 staff members attending. The person sent for evaluation is also present at the meeting, and can answer additional questions from the staff members, but the person can address the staff, too. After the interview, all the staff members consider and decide about the diagnosis and forensic evaluation.

The questionnaire, that was answered by the authors, was made after the data from the first study. The data in the questionnaire consisted of the following: general data (working and marital status, number of children, place of living, age at time of offending, primary family, education, earlier convictions, abuse), psychiatric history (alcohol and drugs usage, earlier hospitalizations and outpatient treatments, diagnoses, pharmacotherapy), data about the offence (the type of the offence, if there are other accused, place of the offence), data about the victim (age, relation to the offender), behaviour during the court procedure (if he confesses the offence, if he gives his defence), behaviour during the offence (use of alcohol and drugs), evaluation procedure regarding sexual history (was he asked about sexual history, masturbation, fantasies), conclusions of the evaluation (intelligence, diagnoses, criminal responsibility, ability to stand trial).

Statistical analyses

The results are presented for the entire sample. The answers for some of the questions (e.g. earlier convictions, abuse, alcohol use, etc.) were dichotomized as “Yes” and “No”. The differences among the two time frame groups were tested, for these type of questions, using χ^2 test.

The level of statistical significance was set at $p < 0.05$. Statistical analyses were performed with the statistical package SPSS 18.

RESULTS

In the first study (1998-2001) there were 50 subjects, all men; in the second (2010-2016) there were 58 subjects, 57 men and 1 woman. In the first study, 24% of perpetrators were in the age group 26-30 (range 17 to 63), now only 14.3% were in that age group. The average age was 37.5±12.1 (range 16-66), so it seems that offenders now are older than 15 years ago.

Table 1. Types of offences sex offenders were accused of

	1998-2001	2010-2016
Rape	25 (50%)	27 (48%)
Sexual maltreatment of a child younger than fifteen	6 (12%)	17 (30%)
Lewd acts	12 (24%)	4 (7%)
Sexual intercourse with a helpless person	1 (2%)	3 (5%)
Coercion to a sexual intercourse/sexual intercourse without consent	4 (8%)	1 (2%)
Satisfying lust in the presence of a child younger than fifteen	1 (2%)	2 (4%)
Sexual intercourse by abuse of position	1 (2%)	0
Abuse of children in pornography	0	2 (4%)

Regarding the offence, Table 1 shows types of offence. There is a difference among the groups regarding the type of the offence (χ^2=9.094; p=0.028). Although half of the offenders were charged of rape in both groups, there is higher percentage of lewd acts in the earlier group, and higher percentage of sex offenders against children in the later.

Table 2. Childhood abuse in sex offenders

	1998-2001	2010-2016
Psychological	20%	23%
Physical	6%	5%
Sexual	0	7%

Table 3. Diagnoses reached during the court evaluation

	1998-2001	2010-2016
No diagnosis	0	4 (7%)
Organic, including symptomatic, mental disorders (F0)	7 (14%)	10 (18%)
Harmful use of alcohol (F10.1)	6 (12%)	7 (13%)
Alcohol dependence (10.2)	16 (32%)	6 (11%)
Psychoactive substance (excluding alcohol) related disorder (F1)	0	4 (7%)
Psychotic disorder (F2)	1 (2%)	0
Affective disorder (F3)	0	3 (5%)
Stress related disorder (F43)	4 (8%)	2 (4%)
Paranoid personality disorder (F60.0)	0	2 (4%)
Schizoid personality disorder (F60.1)	1 (2%)	0
Dissocial personality disorder (F60.2)	21 (42%)	21 (38%)
Borderline personality disorder (F60.3)	1 (2%)	5 (9%)
Dependent personality disorder (F60.6)	4 (8%)	6 (11%)
Narcistic personality disorder (F60.8)	3 (6%)	18 (32%)
Mixed personality disorder (F61)	15 (30%)	1 (2%)
Paedophilia (F65.4)	7 (14%)	4 (7%)
Other paraphilia (F65)	1 (2%)	1 (2%)
Mental retardation (F7)	8 (16%)	3 (5%)

Both groups are similar regarding abuse in childhood (Table 2).

Both groups are similar regarding earlier psychiatric treatment (36% of group 1 and 41% of group 2 subjects were previously psychiatrically treated; either in a hospital or as outpatients). The majority were treated for personality disorders (16% of the first group and 12.5% of the second group) and alcohol related problems (12.5% of the second group, the prevalence not known for the first group).

Distribution of diagnoses reached during the evaluation process is presented in Table 3. In both groups the most prevalent diagnosis is dissocial personality disorder (42% and 38%), followed by other personality disorders (48% and 57%) and alcohol related disorders (44% and 24%). Diagnosis of paedophilia was reached in 14% and 7%. There are some differences among the groups: In the group 1 there were no subjects assessed as not having any of the mental disorders, and high percentage was assessed as having mixed personality disorder, while in the later group, many were diagnosed with narcissistic personality disorder. Also, although the prevalence of harmful use of alcohol is the same, the latter group has much less people with alcohol dependence (almost three times less). Mental retardation is also three times less prevalent in the latter group, compared to the former.

In both groups, more than half (58% and 52%) do not consider themselves guilty for the offence. But, one of the largest differences among the groups is the percentage of those who were not giving their defence during the process – only 4% in the first group and 30% of the subjects in the second group!

In concordance with the diagnoses reached, the majority of subjects were not recommended any kind of treatment. In 20% of the first sample and 13% of the second, the psychiatric treatment was recommended and in 8% and 3% treatment of substance dependence.

DISCUSSION

The number of cases sent to the Centre for forensic psychiatry of the University Psychiatric Hospital Vrapče in the last ten years has diminished. The total number of sexual offences in the same period has increased, but less offenders are sent for a psychiatric evaluation to the institution (Dujmović 1997). There are two possible explanations for this: courts (judges) send less people for the evaluation, or judges choose individual (private) court experts instead of the institution. We believe that the second reason is more probable as the majority of subjects are not diagnosed with mental disorders (even more in the second sample). The choice of the private (individual) court expert is due to the expenses: the individual experts are much less expensive compared to the institution, as the institution employs a much more thorough investigation: EEG, laboratory findings, obligatory psychological evaluations etc. Therefore, some judges will employ private experts, to cut the expenses of the evaluations (on the expense of the quality, we might add, as in the institutional evaluation more experts are engaged, of different specialities – psychiatrists, neurologists, psychologists – and with more comprehensive techniques).

In both of our samples, as in all the samples in the literature, the sex offenders are predominantly men. We had only one woman sent for evaluation in the second time frame. There are many theories regarding the male dominance of offenders among criminality in general, - but also in sexual offenders in particular – from biological theories, based on importance of testosterone on aggressiveness to social theories, taking account of gender roles and gender determined violence (domestic violence and sexual violence – with the majority of the victims being female, and the majority of perpetrators being male) (Lindsay et al. 2004, Gilbert & Focquaert 2015).

Although the average age of the perpetrators was lower in the first group, both groups are comparable to other studied perpetrators: the average age of perpetrators in the majority of research is late thirties to mid forties, with the age range of 17-73, which is very similar to our sample (Valenca et al. 2015, Kim et al. 2017, Stinson & Becker 2011). Therefore, it seems that men of any age (including old age, the oldest person in our sample was 63) commit sexual offences, but the majority are young and middle aged.

As in sexual offending in general, around the world, the most prevalent offence was rape and it was accounted for almost half of the offences (Valenca et al. 2015, Koch et al. 2011). More offences against children were reported in the second time frame, and it is not clear whether there are really more offences against children, or whether this kind of offences are nowdays more easily reported or if in these cases judges more often send the accused for the psychiatric evaluation as they cannot perceive that a person with no mental disorder would commit such a crime. Police reports show that sexual offences against children are now more prevalent than lewd acts and this is probably the reason why we have more of the perpetrators against children sent for the evaluation (Ministry of Internal Affairs 2017).

The most prevalent diagnosis found in our samples is a dissocial personality disorder, diagnosed in 42% and 38%. This is in concordance with other research of sexual offenders (Koch et al. 2011, Stinson & Becker 2011, Harsch et al. 2006). This is not surprising, also for the reason as one of the distinctive diagnostic criteria for dissocial personality disorder is “Failure to obey laws and norms by engaging in behaviour which results in criminal arrest, or would warrant criminal arrest” (criterion A1), together with blatant disregard of safety of others and lack of remorse (APA 2013). For the same reason, the prevalence of dissocial personality disorder is very high among the prison inmates.

There were significantly less people sent for evaluation that were diagnosed with alcohol dependence. Alcohol is a well-known criminogenic factor, which is an important factor in aggressive and sexual crimes due to its disinhibiting properties (Baltieri & de Aldrade 2008). It is not clear why the diagnosis of alcohol dependence was less often diagnosed in the second time frame group. The possible answers could be that there were less people with alcohol dependence (with no apparent reason for that) or that the evaluators became stricter in applying diagnostic criteria.

Another interesting difference is that in the first group there were more people diagnosed with mixed personality disorder, while in the second group more people were diagnosed with narcissistic personality disorder. It is possible that the majority of the mixed personality disorder perpetrators had narcissistic traits among the mixed category. In the second group, the evaluators possibly tried to diagnose one distinct personality disorder, instead of giving the diagnosis of mixed personality disorder. The fact that the sum of these both categories is the same in both groups (36% and 34%) confirms the explanation.

Paedophilia was diagnosed in 14% of perpetrators in the first group and in 7% in the second. Other paraphilias were diagnosed very rarely (only in two cases). Other research of similar populations show similarly low prevalence (Miller et al. 1988, Novak et al. 2007, Harsch et al. 2006). The reasons for diagnosing paraphilias rarely in people who committed sexual offences is probably due to the fact that they do not readily confirm their sexual preferences as they are afraid this would lead to finding them guilty for the crime. So, the evaluators have to rely on other positive finding of their sexual preferences, which are difficult to find and confirm. Therefore, very often the evaluator has to conclude that there are no enough data showing the person has a diagnosis of a paraphilia. Half of the subjects decline the offence, and claim they did not do it. It is expected that a person who says that did not

commit a crime against a child will not readily confirm sexual preferences toward children even if he has them. Also, almost one third of all the subjects in the second group did not give their account of the event (they used the so called "defence by silence") and therefore the evaluators were not allowed to ask questions about the offence. Again, if the person is not willing to talk about the offence in the court, it is reasonable to believe that the same person will not give full accounts about his sexual preferences when accused of a sexual crime. This will make diagnosing sexual preference disorders (paraphilias) more challenging. In the first group there were not many people who used this kind of defence, and the authors concluded that although almost half of the subject sent for evaluation for other crimes (except sexual) use this kind of defence, the sex crime offenders do not employ it. Ten years later it seems that sex offenders use the same defence as other offenders, i.e. defence by silence.

CONCLUSIONS

The most prevalent sex offence reported, in Croatia, is rape. Current sex offenders, compared to sex offenders of 15 years ago have the same prevalence of abuse, earlier psychiatric treatment and the majority of offenders were diagnosed with dissocial personality disorder and other personality disorders. Paedophilia was diagnosed in only a minority of cases. Current sex offenders committed more sex offences against children, more often were with no mental disorder and less often had alcohol dependence and mental retardation. Up to one third of them were not giving their defence.

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Contribution of individual authors:

Goran Arbanas: idea, concept and design of the article, literature searches, data analysis, writing manuscript, approval of the final version.

Paula Marinović: concept and design of the article, data analysis, writing manuscript, approval of the final version.

Nadica Buzina: comments on the concept and design of article, literature searches, approval of the final version.

Miroslav Goreta: comments on the concept and design of the article, approval of final version.

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