DISSOCIATION AND SEX OFFENDING

EXPLORATORY STUDY ON THE RELATIONSHIP BETWEEN DISSOCIATIVE PATHOLOGY AND SEX OFFENDING

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ABSTRACT

Dissociation remains a controversial field of psychology with respect to its etiology, prevalence, and symptomatology. In addition, dissociation is also controversial because of its ubiquitous nature in that dissociation manifests itself in a broad range of severity, across all psychopathology, and also in non-criminal and criminal behavior. The presence of pathological dissociation in the sexual offender population and the consequences of such a presence are the focus of interest in this thesis. The thesis is of a theoretical nature. Extensive literature reviews were employed as investigative methods. The main contribution of the thesis to the knowledge of dissociation and sex offending is proposing a model exploring the presence of dissociative states in the sexual offence process of male adult offenders. This model brings a general concept of elevated dissociation in sex offenders to a more detailed theoretical level. Major conclusions reached in this paper are threefold. Firstly, the prevalence of dissociative pathology in male sex offenders is higher than that in the normal population. However, this conclusion warrants confirmation by further research as it has been based on a limited number of studies. Secondly, the prevalence of childhood sexual, physical, and emotional trauma in male and female sex offenders is significantly higher that that in the normal population. Thirdly, such a trauma is the main etiological factor in the rise of dissociative pathology in the sex offender population. Consequently, a model of dissociation in the sexual offence process of male adult offenders is proposed. Finally, implications for therapy for disociative adult male sexual offenders are discussed, including the addition of a hypnotic element to current cognitive-behavioral programs for sex offenders.

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DISSOCIATION - OVERVIEW

" Subjectively, most of us have a compelling sense of unified self; the self does not seem to us usually to be an illusory entity: ***I*** *was asked to write this;* ***I*** *accepted;* ***I*** *am writing. Indeed, if we did not have a compelling sense of the unitary self, dissociationism would make little sense. ... At some level then, even if only subjectively, there must be a unit for dissociation to arise. Dissociation represents some discrepant manifestation of a system's subsystems; both the system and its subsystems are sine qua nons of dissociation. What is striking about dissociation is that it jars us, unawares, from one system level to another. The subsystem's discrepant manifestations capture our attention, and what we are conceiving of a system we suddenly see, in a Necker-cube fashion, as subsystems, and the previous system level now appears illusory."*

-David Spiegel, 1994

INTRODUCTION

There are heated debates with regard to both the definition and prevalence of dissociation as well as the relationship between dissociation and other psychological disorders. At present these debates appear to occur quite often; one can find them in pop-psychology magazines but also in psychology textbooks and recent psychological research literature. There is an aura of the paranormal, inexplicable, or even the mystic that surrounds a topic of dissociation. The presence of hypnosis in the theoretical model of dissociation appears, at least according to some, to push the concept of dissociation even further towards para-psychology rather than towards mainstream psychology.

Dissociative disorders themselves are extremely fascinating and worth being a focus of attention. Moreover, it appears that dissociation is indicated in several psychological disorders such as Obsessive-Compulsive Disorder, Eating Disorders and Posttraumatic Stress Disorder, and certain types of behaviour or activities such as prostitution, striptease and marathon running. (Schumaker, 1995; Steinberg and Schnall, 2000; Spiegel, 1994). There is also a growing body of evidence suggesting that dissociation might be involved in sexual (Bliss and Larson, 1985) and other types of criminality (Taylor and Kopelman, 1984).

HISTORICAL BACKGROUND

Dissociation appears to be a fundamental and universal component of human psychology. Ross (1994) states that the history of dissociation begins in prehistoric times, with the ecstatic experiences of the shamans. He also stresses that the psychological foundations of dissociative disorders are illustrated by the trance and possession states found in most cultures throughout history.

JANETIAN AND FREUDIAN DISSOCIATIONS

The dominant model of dissociation in nineteenth-century psychology and psychiatry was a psychopathological one. According to this model, dissociation occurred because of a defect or deficit in ego strength (Ross, 1996). Ross (1996) praises the late nineteenth-century dissociative models of psychopathology that were not narrowly focused on the disorders classified as dissociative in DSM-IV. Such broad-based models included conversion disorder, somatization disorder, somnambulism, some forms of obsessive-compulsive disorder, and everything encompassed under the term hysteria.

In the history of nineteenth-century psychology, two types of dissociation have been described, though they may have been assigned different terms. Spiegel (1994) talks about *Janetian dissociationism* and *Freudian dissociation.* The first concept was defined as a deficit phenomenon in that there is a splitting-off of personality clusters from the *ego,* the core personality resulting from insufficiency of binding energy caused by hereditary factors, life stresses, or traumas or an interaction among them. As a

consequence of the splitting off process, disconnected clusters or fragments constitute minipersonalities or, if they cohere, an alternate personality clusters or fragments. Unlike Janet, Freud (at least at some stage) perceived dissociation as an active defense phenomenon against the trauma. Hence, subsystems of ideas/wishes/thoughts/memories that threaten the integrity of the overall system are forcibly suppressed/repressed/inhibited/dissociated/split off, and so on (Spiegel, 1994). According to such a view, the memory of the traumatic event became dissociated and 'was placed' in a separate level of consciousness, from where it could produce hysterical symptoms. However, the concept of dissociation was finally abandoned by Freud in favor of repression, a basic concept of the psychoanalytic theory. According to this concept, a repression barrier served to prevent unacceptable information from reaching consciousness (Schumaker, 1995). Frankel (1994), considers that the Freudian explanation of dissociation dominated the English-speaking Western world until the early 1970s when the academic world revisited Janet's theory.

RESEARCH ON DISSOCIATION IN THE 1970 AND 1980s

Ross (1994) states that interest in dissociation, from its peak in the last two decades of the nineteenth century, went down to virtually zero from the 1920s to the 1950s. There were several factors that led to such neglect of that topic by academia. These were: Freud's shift from a dissociation to a repression model in psychopathology, the creation of the term *schizophrenia* by Bleuler, and the rise of behaviorism.

Finally, the curve of interest in dissociation turned upward during the 1980s, and the field began to undergo exponential growth. It appears that that sudden turn was caused

by four major factors. Firstly, childhood physical and sexual abuse was brought out of the closet by the women's movement. Secondly, the Vietnam War changed the perception of psychology and psychiatry of the consequences of severe trauma. The third factor was the publication of the books *The Three Faces of Eve* (Thigpen and Cleckley, 1957) and *Sybil* (Schreiber, 1973) and the release of the movies based on these stories; these two cases brought dissociation into mainstream consciousness. The fourth factor was the acknowledgement of dissociative disorders by the DSM-III as a separate category.

DEFINITIONS AND CLASSIFICATION

DISSOCIATIVE CONTINUUM

Definitions and classification of dissociation have caused immense difficulties, and as a consequence various definitions and taxonomies of dissociation have been proposed. The term "dissociation" appears to have a great semantic openness which is acknowledged by Cardena (1994, p. 15):

> 'dissociation' has been used as a descriptive or explanatory concept for such apparently disparate phenomena as hypnosis, perception without awareness, and automatic behaviors; to distinguish between various types of memory; in relation to some forms of psychopathology, some cognitive responses to trauma and particular neurological symptoms; and to account for differential performance on word comprehension exercises.

It seems that there are three distinct ways that dissociation has been described within the field of clinical psychology. First, the term dissociation is used to characterize semi-independent mental modules or systems that are not consciously accessible, and/or not integrated within the person's conscious memory, identity, or volition. Second, dissociation is often considered as representing an alteration in consciousness wherein the individual and some aspects of his/her self or environment become disconnected or disengaged from one another. Finally, dissociation is viewed as a defense mechanism that affects such disparate phenomena as nonorganic amnesia, the warding off of current physical or emotional pain, and other alterations of consciousness, including a chronic lack of personality integration, such as with Dissociative Personality Disorder (DID) (Cardena, 1994).

Moreover, Ross (1996) states that dissociation consists of three factors: absorption-imaginative involvement, amnesia, and depersonalization-derealization. Absorption appears to be the most common subcomponent of dissociation in all populations studied; the other two factors tend to be clearly psychopathological in nature when elevated item scores occur. The concept that dissociative disorders lie on a continuum of increasing complexity, chronicity and severity related to trauma is widely accepted in the field (Ross, 1996). According to the continuum model, at the left of the continuum is normal dissociation with examples such as day-dreaming, trancing out for a few blocks while driving a car, absorption in a book or movie, and normal childhood imaginative play. Further towards the right on the continuum one can expect more pathological forms of dissociative and trance-state phenomena, such as highway hypnosis, which are not freestanding psychiatric disorders. Finally, simple dissociative disorders such as dissociative amnesia disorder that are followed by more complex and

chronic forms of dissociative disorder not otherwise specified, can be found with DID at the far-right end of the continuum.

However, Cardena (1994) mentions that there are other concepts in the taxonomy of dissociative disorders which he proposes should be arranged according to the type of mental process not integrated, including sensation, memory and volition. In a similar vein, Kihlstrom (1994, p. 384) suggests a new system of classification stating that

> the dissociative disorders may be further classified according to the specific mental functions affected by the alteration in consciousness: memory and identity, sensation and perception, and voluntary action.

CLASSIFICATION

Dissociative experiences

Cardena (1994) presents a useful heuristic device (Fig. 1) that embraces various aspects of *dissociative experiences*.

PATHOLOGICAL

Blindsight	Dissociative Identity Disorder (MPD)
Comissurotomy	Depersonalization/derealization
Organic amnesia	Dissociative amnesia
Epileptic fugues	Dissociative fugues
Hemineglect	Conversion disorder
NEUROLOGICAL	**PSYCHOLOGICAL**
Drug-dependent learning	Hypnosis
Sleep amnesia	Out-of-body experiences
	Automatisms

NORMAL

FIGURE 1. Dissociative phenomena (from Cardena, 1994).

According to Cardena (1994), the upper right quadrant of the figure displays four psychological syndromes that the DSM-IV currently categorizes as dissociative, with the addition of conversion disorders. Such syndromes involve disruption in the usually integrated functions of consciousness, memory, identity, or perception of the

environment and are not primarily neurological in nature. The upper left quadrant (Figure 1) presents conditions wherein a lack of integration between conscious experience and behaviours is the product of brain injury or malfunction. The nonpathological phenomena that are primarily produced by psychological and social variables, such as deployment of attention and expectations, are displayed in the lower right quadrant. Finally, the lower left quadrant shows "ordinary" types of amnesia that have been viewed as forms of dissociation involving different psychobiological states (Cardena, 1994).

Dissociative disorders

According to Ross' (1996) model of the dissociative continuum, dissociative disorders lie on the far right hand of that continuum and appear to be characterized by greater severity of symptoms than other dissociative experiences.

The diagnostic and statistical manual of mental disorders DSM-IV (American Psychiatric Association, 1994) distinguishes five dissociative disorders:

1. Dissociative Amnesia
2. Dissociative Fugue
3. Dissociative Identity Disorder (Multiple Personality Disorder)
4. Depersonalization Disorder
5. Dissociative Disorder Not Otherwise Specified

THEORIES OF DISSOCIATION

EMOTIONAL DISSOCIATION IN RESPONSE TO TRAUMA

Foa and Hearst-Ikeda (1996) propose a notion that dissociation or "numbing" may represent a strategy for reducing or avoiding trauma-related emotional distress. According to that hypothesis, dissociation impedes emotional processing and consequently impedes recovery. This view has been supported by the repeated finding that dissociation, during or immediately after the traumatic experience, is associated with later psychopathology (Foa and Hearst-Ikeda, 1996). It has been proposed that excessive use of dissociation prevents the activation of the traumatic memory, and that repeated activation is a necessary condition for emotional processing to occur (Foa and Hearst-Ikeda, 1996). Such a hypothesis clearly indicates that dissociation is one factor that underlies the persistence of posttrauma disturbances, and thus it is implicated in the development of chronic Posttraumatic Stress Disorder (PTSD) and related psychopathology (Foa and Hearst-Ikeda, 1996).

DISSOCIATION AND HYPNOSIS

Historically, a close relationship between hypnosis and dissociation has been assumed, based on four fundamental observations concerning both concepts. These observations are: 1) phenotypic similarities (between hypnotic alterations in perception and sensation, and behavioral and experiential phenomena characteristic of dissociation); 2) hypnosis as an effective treatment; 3) subjective similarities between normal hypnotic subjective experiences and dissociative subjective experiences; 4) common traumagenic etiology for hypnotizability and dissociation (Whalen and Nash, 1996).

Frankel (1994) emphasizes that the clinical roots of dissociation lie embedded in the history of hypnosis. Janet considered hysteria and hypnosis as almost identical, and dissociation the mechanism accountable for both of them. Whalen and Hash (1996) state that there are two contemporary theoretical traditions that attempt to explain a link between hypnosis and dissociation. One evolves from early clinical work with dissociative patients while another originates in cognitive psychology. The first theoretical stand of dissociation proposes that early childhood trauma leads to repeated overuse of dissociation until it becomes the individual's primary defense. Such defense can manifest itself in dramatic alterations in the experience of self and world. In general, this model defines a causal continuity between trauma in childhood and subsequent adult symptoms. This model also proposes a therapeutic age regression as a treatment technique.

The second theoretical tradition that assumes an underlying shared process in hypnosis and dissociation is Hilgard's neodissociation theory. Hilgard (1994) proposed a hierarchical system of cognitive control such that the relationship between the higher executive levels and actual behaviour become transiently disconnected. Such disconnection, associated with an amnesic barrier, appears to account for apparent involitional experiences of hypnotic subjects. According to Hilgard (1977), both hypnotic and dissociative pathological states are characterized by intense absorption, amnesias, fantasy proneness, automatism, depersonalization, experience of involuntariness, and cognitive inconsistencies. Therefore, hypnosis and dissociative disorders may share important underlying psychic mechanisms. However, Whalen and Nash (1996) caution that a potential link between the constructs of dissociation and

hypnosis is complex and indirect. Moreover, several propositions, originating in the assumption of a hypnosis-dissociation link, are not supported empirically.

DISSOCIATION AND OTHER PSYCHOPATHOLOGIES

Schumaker (1995, p.175) states that: "There is a growing sentiment that most, if not all, types of clinical psychopathology involve some degree of dissociation and concomitant autosuggestion." Significantly higher levels of cognitive dissociation have been found in persons with borderline personality disorder (Ross, 1996), DID, Briquet's syndrome, phobias, anorexia nervosa, sociopathy, criminality (Bliss, 1984), conversion disorder, posttraumatic stress disorder (PTSD) and bulimia nervosa (Chu, 1996; Schumaker, 1995). Several of these pathologies such as anorexia nervosa, bulimia nervosa, PTSD, and conversion disorder appear to have very strong dissociative components; therefore, some researchers (Schumaker, 1995; Kilhstrom, 1994) suggest that these disorders should be classified as dissociative.

A relationship between borderline personality disorder and dissociative disorders appears to be quite strong, as a ninth criterion for borderline personality disorder in the DSM-IV has been described as: "transient, stress-related paranoid ideation or severe dissociative symptoms" (American Psychiatric Association, 1994, p. 428). Ross (1996, p. 13) assumes an extremely close relation between these disorders by stating:

> To my way of thinking, borderline personality disorder is a simple form of DID in which the personality states are less crystallized, less

> personified, fewer in number, and not separated by the same degree of amnesia. Inversely, DID is a complex variant of borderline personality disorder.

High comorbidity between dissociative disorders and borderline personality disorder appear to be explained by high rates of childhood trauma for patients in both groups (Ross, 1996).

Most of the psychological literature acknowledges a commorbidity between obsessive-compulsive and dissociative disorders (Grabe, Goldschmidt, Lehmkuhl, Gaensicke, Spitzer, and Freyberger, 1999). However, some research appears to question the existence of such comorbidity (Goff, Olin, Jenike, Baer, et al., 1992). Moreover, the nature of this assumed relationship remains unknown. Pica, Beer and Maurer (1997) postulate that patients from both groups show an inability to attend to new facts, respond to changes in the environment, and assimilate and accommodate peripheral information into pre-existing schemas about the self and the world.

There is a large body of literature that explores the relationship between eating disorders such as bulimia nervosa and anorexia nervosa, and dissociation. Some research indicates that dissociative phenomena such as self-hypnosis, hypnotic anesthesias, hypnoidal states, ego states and depersonalization might be operational components of anorexia and bulimia (Katz, 1996). Therefore, Katz (1996) believes that positive autohypnotic suggestions might be a useful treatment modality to reverse patients' aberrant eating behaviours. This therapeutic approach also appears to be warranted by findings implicating high levels of hypnotizability in bulimics and possibly anorexics

(Groth-Marnat, 1991). The research by Schumaker, Warren, Carr, Schreiber, and Jackson (1994) confirms a relationship between both anorexia and bulimia, and depression and dissociation. Their eating disordered subjects scored significantly higher on depression and dissociation measures than control subjects.

The notion that the elevated levels of dissociative symptoms in persons with eating disorders originate in a history of abuse was not confirmed by research (Finn, Hartman, Leon and Lawson, 1986). Schumaker (1995) proposes a model that assumes that persons who are predisposed to eating disorders utilise dissociative strategies to gain some personal control. Issues of personal control, sense of self and autonomy are crucial in current conceptualizations of such disorders. Such a stand appears also to add a valuable development to the etiology of eating disorders. Dissociative states in persons predisposed to eating disorders can make them particularly vulnerable to suggestion (for example, cultural suggestions relating to the ideal body).

Elevated dissociative states in persons with PTSD appear to come as no surprise as a trauma has been considered currently to be a core element in the etiology of dissociative disorders (Foa and Hearst-Ikeda, 1996). Further research that addresses the potential presence of dissociation in a wide range of psychopathologies seems to be particularly important. The results of such types of research might contribute greatly to a better understanding of the etiologies of psychological disorders and the development of modified and improved therapies.

DISSOCIATION AND CRIME

Psychological literature has recently shown a greater interest in the presence of dissociation in some forms of criminal offending. The research appears to be preoccupied mainly with the presence of dissociative states and disorders amongst sex offenders. However, the literature also shows that dissociation has been investigated in women's offending and amongst prison inmates. The most controversial and perhaps the strongest liaison between dissociation and criminality is when persons with DID or another dissociative disorder commit a crime and claim that they have no memory of the offense, or that the other personality is responsible for the offense. Finally, there seems to be some similarity between a concept of cognitive deconstruction and that of dissociation with respect to their role in criminal offending.

SEX OFFENDING

There is a large body of literature that acknowledges the presence of dissociation in sex offending. Such evidence appears to come as no surprise as early physical, sexual and psychological abuse, that can lead to the development of dissociation, is more prevalent amongst sex offenders than that in the general population (Bliss and Larson, 1985, Ellason and Ross, 1999). Graham (1996) points out that the childhood victimatization of sex offenders has been badly underestimated, mostly because of underreporting by male offenders of their sexual abuse. Such underreporting might occur due to increased shame associated with male victimization and a high level of denial. Graham (1996) believes that by creating a safe treatment milieu one can obtain "true" levels of offender victimization. He reported that 70% of his sample of sex offenders admitted to being

sexually abused as a child and 50% admitted to physical abuse. However, it is also possible that dysfunctional dissociation in some offenders might develop through other than trauma related pathways.

Most of the literature that addresses issues of dissociation in sex offending acknowledges the higher prevalence of dissociative states amongst sex offenders than in the general population (Ellason and Ross, 1999; Graham, 1993). Graham (1996) reported that offenders who were physically abused by both parents reported higher levels of dissociation than other groups of offenders. Moreover, Bliss and Larson (1985) found that their group of sex offenders obtained significantly higher hypnotizability scores than controls.

CRIME COMMITTED BY WOMEN

There is a wide range of psychiatric conditions, including PTSD, a dissociative-like disorder, that have higher prevalence rates amongst incarcerated women than in the general population. The presence of dissociation in women's offending appears to be related to high rates of childhood sexual abuse amongst incarcerated women. Zlotnick's (1997) research shows that 41 of 81 incarcerated women met the criteria for current PTSD and 17 for lifetime PTSD. Moreover, the women with PTSD were more likely to report higher levels of dissociative experiences. Results of research by Browne, Miller and Maguin (1999) show that the lifetime prevalence rates of female inmates, reported in this study, exceeded those for all acts of physical abuse reported by women in the general population. Bliss and Larson (1985) state there is a high incidence of hysteria in incarcerated female felons. This finding led the authors to the conclusion that:

> female hysteria (Briquet's syndrome) probably is a 'spontaneous self-hypnotic disorder' with self-hypnosis producing a polysymptomatic syndrome including amnesias, dissociations, conversions, hallucinations, and multiple personalities (Bliss and Larson, 1985, p.524).

DISSOCIATION IN JAIL POPULATION

Some recent literature addresses issues of dissociation in a jail population. Morgan (1996) conducted an experiment consisting of 25 months of naïve, continuous participant observation and concluded that severe dissociative disorders may be common in inmates. The author also presents implications of his findings such as the development of programs for correctional institutions by experts in dissociative disorders. Morgan (1996, p.96) believes that such an approach

> would lead not only to a better understanding of the relationship of dissociative disorders to crime, but also to better programs for the non-violent, self-destructive, dissociative inmates who are jailed in disproportionately large numbers.

In a similar vein, Snow, Beckman and Brack (1997) found that dissociative experiences of their subjects from a jail population were much higher than in the general population. The authors speculate that such findings might indicate that the jail population consists of a higher percentage of persons suffering from posttraumatic stress disorder, or these scores might be indicative of the stress associated with a jail environment.

DISSOCIATIVE IDENTITY DISORDER IN FORENSIC PSYCHIATRY AND AMNESIA FOR CRIMINAL OFFENCES

Amnesia for criminal offences appears to be related to violent crimes only and is most frequent following homicide. It has been suggested that a variety of mechanisms can be proposed to account for the amnesia, including dissociation, repression, and alcoholic black-outs (Taylor and Kopelman, 1984). Similarly, Hopwood and Snell (1993) list three factors that might contribute to non-organic amnesia: failure of association, dissociation and repression. According to the authors, dissociation might explain some of the cases of total and permanent amnesia. Such cases appear to be characterized by the tendency for the beginning and end of the amnesic period to be sharply defined.

The issue of DID in a field of forensic psychiatry appears to be very controversial because of questions concerning its ethical and scientific validity. DID's controversial nature seems to be linked with the possibility of simulating a dissociative disorder and getting away with, for example, a murder. Ross (1989, p.75) succintly summarizes the whole debate around DID in forensic settings:

> The simple solution to the artifactual creation of MPD (Multiple Personality Disorder) in criminal cases is that mental state and psychiatric history should be irrelevant to a determination of guilt. ... But should mentally ill criminals be treated the same as other criminals? No, of course not. They need psychiatric treatment if they have treatable psychiatric disorders. Such treatment is in the best interests of both the criminal and society.

DISSOCIATION VS COGNITIVE DECONSTRUCTION

The concept of cognitive deconstruction appears to resemble the concept of dissociation. Baumeister (1990) defines the notion of cognitive deconstruction as the attempted refusal of meaningful thought, particularly with reference to integrative, interpretive mental acts. Characteristics of the state of cognitive deconstruction that is a reduction of inhibitions; the sense of time being drastically limited to the present; goals becoming extremely short-term; and behavior being often impulsive or characterized by the lack of anticipated consequences, seem similar to the characteristics of dissociation. In addition, cognitive deconstruction has been indicated in psychopathologies and behaviors in which dissociation plays an important role. These psychopathologies and behaviours are: anxiety disorders, bulimia nervosa, alcohol use, running marathons, and dancing for hours (Baumeister, 1990).

The notion of cognitive deconstruction has also been discussed in relation to sex offending. Ward and Hudson (1995) argue that the construct of cognitive deconstruction can be indicated in the theoretical explanatory framework of sexual offending. The authors speculate that a key factor in triggering an offense, or an offense pattern, is the vulnerability of the potential offender. Such a person feels inadequate and might experience painful self-evaluation when faced with such vulnerability, and as a consequence he/she is likely to engage in a cognitively deconstructed state. There are also some differences between these concepts of cognitive deconstruction and dissociation and one should not perceive them as an identical construct with two different names.

DISSOCIATION AND CRIME: IMPLICATIONS FOR THERAPY

The psychological literature appears to show that the prevalence rates of dissociation amongst various criminal populations tend to be higher than in the general population. Further research should explore whether a similar tendency is present amongst other groups within a criminal population such as violent offenders. In addition, such research should also determine whether increased dissociative capacities amongst criminals are a pre-offense condition, or a symptomology that develops during imprisonment, or perhaps a combination of pre-offence dissociative abilities and those acquired while in jail.

To date research data about increased dissociation in the criminal population seems to indicate the need for the development of therapies for offenders with dissociative disorders. Therapies that address dissociation or dissociative disorders in criminals might decrease re-offending. In addition, prison based rehabilitation programs that "treat" dissociative pathology might be of great help in making prisoners' life more bearable while in prison and when released (for example, dissociative experiences related to PTSD). Moreover, such programs might also alter inmates' behavior in that their behaviour will be more manageable for prison officers.

Several approaches to therapy with offenders who have dissociative states utilise hypnosis. Hypnotherapy and its variations appear to be a potential treatment modality for offenders with dissociative disorders because of the close theoretical links between

hypnosis and dissociation. Spear (1975) utilized hypnosis-induced altered states of consciousness, along with other techniques such as various models of interior reflection, behaviour modification and reprogramming of conscious attitudes and values, with 49 borderline recidivists. A one year follow-up of 32 offenders showed that the recidivist rate among this group was less than 5 %. Spear (1975) claimed that non-drug induced states of consciousness combined with indirect and symbolic techniques may prove to be the most effective means of criminal rehabilitation.

Guyer and Van Patten (1995) employed hypnotherapy in the treatment of 10 incest offenders. The therapeutic process consisted of several stages. These are some examples of such stages: education and orientation of the offender concerning the hypnotic procedures to be used; development of hypnotic skills in the offender through both hetero-hypnosis and self-hypnosis; age regression; and reeducation of the offender's inner child. Unfortunately, the authors were not able to test the efficacy of their therapy because all their subjects were currently incarcerated with lengthy prison sentences ahead of them. However, all the participants indicated that the treatment had a profound, posistive impact on them and their view of their sexual behaviour. Moreover, according to Guyer and Van Patten (1995), positive changes were also noticed by other therapists and correctional officers.

Carich and Metzger (1999) report a case study in which the treatment of the sex offender consisted of hypnotherapy and contemporary sex-offender treatment. The hypnotherapeutic component (one hypnotic session) was introduced toward the very end of treatment. The authors state that the main aim of the hypnotic session was to conclude 10 years of intensive group treatment by emphasizing therapeutic messages,

such as further resolving past developmental and core issues at both conscious and unconscious levels of awareness, future preparation in terms of coping with high-risk factors, ego strengthening, enhancing deviant arousal control, and others. This hybrid type of intervention appears to be an interesting and also time and cost-effective development in the treatment of sex offenders. Future research should test this treatment approach by means of a statistical analysis. Scott (1982) employed group hypnotherapy with delinquent girls. This approach claims that group hypnosis can be useful in uncovering deeply seated trauma and other core problems, which can consequently be faced together in the group.

OBJECTIVES OF THE THESIS

This thesis is of a theoretical nature and its purpose is threefold. Firstly, currently available evidence will be presented on the higher prevalence of dissociative disorders and dissociative states amongst sex offenders than amongst the general population. This evidence will take the form of a literature review that addresses the presence of pathological dissociation in male and female sex offenders.

Secondly, the theoretical explanation of the link between sex offending and dissociation will be examined in that the etiology of pathological dissociation in men and women who sexually offend will be investigated. Moreover, the presence of pathological dissociation in sex offending will be discussed and a model of dissociation in the sexual offense process of male offenders will be proposed.

The model proposed will attempt to identify stages of the sexual offence that may be accompanied by dissociative states. In addition, the consequences of such a presence will be discussed in the thesis. Current psychological literature and research regarding dissociation in sex offenders appear to remain at the broad and general theory level. The model proposed here brings this general concept of elevated dissociation amongst sex offenders to a more detailed theoretical level.

Thirdly, implications for the treatment for dissociative sex offenders will be proposed. First, therapies that may be potentially useful in the treatment of dissociative pathology in male sex offenders will be critically discussed. Second, the addition of a hypnotic element to current cognitive-behavioral programs for male sex offenders with elevated dissociation will be proposed in this thesis. Cognitive-behavioural rehabilitative programs for sex offenders have been widely used in correctional settings and acclaimed as the most effective treatment, if they possess some specific characteristics (Gendreau, 1996). However, this thesis assumes that hypnotic elements might be an efficacious additional component in the rehabilitation of sex offenders who have elevated scores on hypnotizability or dissociation measures.

Finally, the term "pathological dissociation" utilized in this paper does not indicate that only *Dissociative Disorders* are a focus of attention here. Dissociative states and other dissociative experiences that do not fulfill "official" diagnostic criteria but may however cause distress to persons who experience them are also of interest in this thesis. Therefore, in order to simplify the terminology of the thesis, the term "pathological dissociation" is used here for both typical disociative disorders and other, perhaps

milder forms of dissociation. Such a simplification of the terminology appears to be justified by the suggestion that dissociative disorders lie on a continuum (Ross, 1996).

CHAPTER II

DISSOCIATION AMONG SEX OFFENDERS

This chapter presents evidence of elevated dissociation in sex offenders. Such evidence will be shown in the form of results from direct measures of dissociation, the prevalence of pathologies in which dissociation is clearly indicated (e.g., Posttraumatic Stress Disorder, Borderline Personality Disorder), and clinical symptomatology present in sex offenders that might be indicative of pathological dissociation (e.g., amnesia for the offense).

Classification of sexual offending is a very important and also controversial issue with regard to ethics. However, this issue will not be discussed in this thesis. This paper adopts the subcategories of male sex offences proposed by Maletzky and McGovern (1991). These are: heterosexual pedophilia, homosexual pedophilia, exhibitionism, rape, public masturbation, voyerism, frotteurism, transvestism, fetishism, obscene telephone calls, sadomasochism, and zoophilia. The typology of female sex offenders appears to comprise three major groups. Matthews (1996) proposes the following categories of women who sexually offend: teacher-lover, predisposed, and male coerced. Saradjian (1996) offers a similar classification of female sex offenders with three types such as

women who initially target young children, women who initially target adolescents, and women who are initially coerced by men. The typology of male and female sex offenders is included here mostly for informative purposes. In general, this paper adopts Ryan's (1997, p.3) definition of sexually abusive behavior:

> Sexually abusive behavior has been defined as any sexual interaction with person(s) of any age that is perpetrated (1) against the victim's will, (2) without consent, or (3) in an aggressive, exploitative, manipulative, or threatening manner.

DIRECT MEASURES OF DISSOCIATION IN SEX OFFENDERS

There is sparse research that addresses pathological dissociation in sex offenders. Ross and Ellason (1999), for example, conducted a study in which they compared rates of childhood trauma and dissociative symptoms in 14 male sex offenders receiving inpatient treatment, with 97 adult inpatients receiving treatment for childhood sexual trauma. The authors found by means of structured interview that 77% of men who sexually offend (incest, paraphilia, and exhibitionism) and 92% of sexual trauma inpatients were diagnosed with dissociative disorders. The distribution of such disorders in the sample of male sex offenders was as follows: Dissociative Amnesia (38.5%), Depersonalization Disorder (38.5%), both Dissociative Amnesia and Depersonalization Disorder (23.1%), Dissociative Identity Disorder (38.5%), Dissociative Disorder Not Otherwise Specified (15.4%). Two psychometric instruments to measure and diagnose pathological dissociation, the Dissociative Experiences Scale (DES) and the

Dissociative Disorders Interview Schedule (DDIS), were administered. Dissociative symptoms reported among Ross and Ellason's (1999, p.108) sample subjects included:

> Large childhood memory blanks beyond the age of five; disremembered actions; flashbacks of unpleasant memories; periods of derealization and unreality; internal voices from inside of the patient's mind; and, in slightly over one third of subjects, the sensation of a separate, internal identity state that takes control of the body.

Ross and Ellason (1999) believe that one of the clinical implications of their study is that dissociation may need to be addressed in therapy. Unfortunately, Ross and Ellason's (1999) sample is relatively small and highly biased. Therefore, their findings warrant further confirmation with larger samples of subjects randomly assigned to different groups.

Graham (1993) compared 42 sex offenders, 26 non-sex offenders, and 42 men from a community control group with respect to three factors: dissociation, locus of control, and alienation. The sex offender group comprised 26 men (62%) who have sexually abused children (the primary charge being incest); 6 men (14%) who have been convicted of sexual assault against adult women; and 10 pedophiles (24%). The Dissociative Experiences scale was used in this study as a measure of dissociation. The analysis of variance (ANOVA) showed a significant difference between dissociation in the sex offenders and the non-sex offender group. In addition, the difference between the means of the dissociative scores in the sex offenders and community group means was found to be significant. There was no significant difference found on dissociative

measures between the community and non-sex offender groups. This study appears to be methodologically sound with respect to its way of recruiting subjects. The non-sex offender and community groups were matched with the sex offenders with respect to age and years of education. The means of age and years of education in all three groups appear to be at a very similar level; however, statistical means appear to be necessary to show that there are not significant differences between these group means.

A study that explores dissociation and hypnotizability in sexual offenders was conducted by Bliss and Larson (1985). They found that 67% of their sample of 33 sex offenders (18 rapists, 9 pedophiles, and 6 incest child sex offenders) had "histories of 'spontaneous self-hypnotic' experiences (dissociations)" (Bliss and Larson, 1985, p. 522). Further, 7 of these subjects were diagnosed with Multiple Personality Disorder according to the DSM-III criteria, whereas 6 others were considered to be probable patients with that disorder. Another 9 subjects were considered to be "spontaneous self-hypnotic" as they revealed possible dissociative experiences in two or more dissociative, descriptive categories (dissociations at the time of the crime, past possible dissociative experiences, dissociative fantasies before the crime, presence of multiple personality states).

Of 22 subjects (67%) characterized by pathological dissociation of a different degree, three were incest sex child offenders, 7 pedophiles, and 12 rapists. Psychiatric syndromes, including Dissociative Disorders, were diagnosed with the use of a self-report questionnaire, with 305 items indicating symptoms characteristic of 11 major psychiatric syndromes. These items came from the Research Diagnostic Criteria (an operational diagnostic procedure that was incorporated into DSM-III); protocols devised

by the Washington University Group in Saint Louis; symptoms from the literature often reported by patients with multiple personality; the Minnesota Multiphasic Personality Inventory; and symptoms of hyperactive children.

The Stanford Hypnotic Susceptibility Scale (Form C) was administered in order to measure hypnotizability in experimental subjects and controls. In general, sex offenders as a group (29 were tested) scored significantly higher than controls on measures of hypnotizability. Further, the dissociated group (22 offenders) had very high hypnotizability scores (9.0 - .27) whereas the non-dissociated group had scores at the level of controls (6.6 - .57). In addition, the dissociated group appeared to be polysymptomatic in that it had more symptoms, except for alcoholism, than the nondissociated group and the controls in all 11 categories.

Moreover, hypnosis was tried with most offenders to assess clinically their hypnotic abilities and detect possible cases of Dissociated Identity Disorder. However, the results of clinical trials with hypnosis were not presented in Bliss and Larson's (1985) article. This study yields immensely interesting results that appear to create a base for the hypothesis of elevated dissociation and hypnotizability in the sex offender population. However, Bliss and Larson's (1985) research is plagued by several flaws. Firstly, as the authors admit, their group was a selected population with respect to age (17-35), IQ (normal), status (all had been to trial), and acknowledgment of their crime. Secondly, the diagnosis of psychiatric syndromes was based purely on self-report measures. It appears that the validity of such diagnosis could be enhanced if interview-like forms of assessment were utilized.

The results of the three studies presented above appear to confirm the hypothesis about elevated dissociation in the sex offender population. However, the outcome of the study by Dwyer, Rosser and Sawyer (1992) does not confirm such a hypothesis. The authors compared levels of dissociation between 71 sex offenders and 14 men falsely accused of sex offending. Their experimental group of men who sexually offend (71) comprised 34 (45.8%) pedophiles and 38 (54.2%) incest offenders, exposers, voyeurs, and obscene phone callers. The Dissociative Experiences Scale was administered to sex offenders and controls as a measure of dissociation. Dwyer et al. (1992) found that their sex offender sample scored in the range typical for the normal population. The dissociative score of persons falsely accused was lower than the score of the sex offenders and general population. A difference between the means of sex offenders and persons falsely accused was described by the authors as a "trend", though such a difference was not statistically significant.

Dwyer et al.'s (1992) study appears to be plagued by two methodological weaknesses. The first major shortcoming in this area is the use of highly pre-selected groups (with respect to normal IQ, desire to change their offending behavior, and admission to at least one offense). The second shortcoming is related to additional exclusion criteria in a selection process (presence of antisocial personality disorder or history of violence). Both shortcomings might have possibly decreased the representativeness of the experimental sample. Other methodological shortfalls are the great heterogeneity with regard to the type of offense within a sex offender group and the small number of participants in the falsely accused group.

SEX OFFENDERS AND DISSOCIATION-RELATED PSYCHOPATHOLOGIES

This section will critically evaluate the psychological literature that indicates the presence of psychopathologies closely linked with dissociation in the sex offender population. One such pathology is Borderline Personality Disorder (BPD), whose relationship to dissociative pathology has been suggested because of the common traumatic etiology of BPD and pathological dissociation (Ross, 1996). It is well established that BPD patients, similar to persons with dissociative disorders, have high rates of childhood trauma (Gunderson and Sabo, 1993). Moreover, dissociative symptoms are one of the criteria of Borderline Personality Disorder (DSM-IV, 1994). In addition, a high comorbidity between BPD and Dissociative Identity Disorder (DID) also appears to confirm the relationship between BPD and pathological dissociation. It has been found that 38-70 % of patients with DID meet the criteria for BPD (Horevitz and Braun, 1994).

Berger, Berner, Bolterauer, Gutierrez and Berger (1999) investigated the relationship of Sadistic Personality Disorder (SPD), as defined in the appendix of DSM-III-R, to other personality disorders and to sexual sadism. The major investigation of the study is irrelevant here. However, Berger et al.'s (1999) research also provides information about the distribution of major personality disorders, including Borderline Personality Disorder, in their sample. The authors assessed 70 sex offenders (27 child sex molesters, 33 rapists, and 10 murderers) with the use of the International Personality Disorder Examination. Borderline Personality Disorder was diagnosed in 11 subjects (15.7%). Other personality disorders diagnosed in the subjects, according to DSM-III

criteria, were Sadistic Personality Disorder (27.2%), Antisocial Personality Disorder (25.7%) and Paranoid Personality Disorder (21.4%). In general, 62 subjects (88.6%) of Berger et al.'s (1999) sample exhibited at least one personality disorder. In addition, Berger et al. found a 31.6% overlap between Sadistic Personality Disorder (diagnosed in 27.2% of subjects) and Borderline Personality Disorder.

Berger et al. (1999) acknowledge several limitations of their study. These are: small sample size, evaluation of psychiatric diagnoses by unblinded investigators, lack of a control group (including a non-sex offender group), lack of the representativeness of the sample (referrals from prison or probation to enter a voluntary treatment program), and lack of a sound neurological assessment. Despite such limitations, Berger et al. (1999) conclude that their findings, that persons who commit sexual offenses may have high rates of various psychiatric disorders, are consistent with previous observations.

Generally, the findings of Berger et al. (1999) provide a very tenuous argument supporting our hypothesis of elevated dissociation in sex offenders. Their 11 subjects might have been possibly diagnosed as "borderlines," though it does not necessarily mean that they had any dissociative symptoms whatsoever. In addition, Berger et al. (1999) reported neither a general rate of childhood physical and sexual abuse of their group, nor such a rate for each group diagnosed with a different personality disorder.

In addition, Posttraumatic Stress Disorder (PTSD) seems to have close links with pathological dissociation because of their common etiology. It has been postulated that dissociation occurs at the time of traumatization, particularly in those individuals who progress to develop PTSD (Krystal, Bennet, Bremner, Southwick and Charney, 1996).

In addition, 'dissociative flashback episodes' are one of the DSM-IV diagnostic criteria for PTSD. Krystal et al. (1996) perceive flashbacks as the most distinctive PTSD symptom that represents the convergence of dissociative states, intrusive traumatic memories, and hyperarousal.

McElroy, Soutullo, Yaylor, Nelson, Beckman, Brusman, Ombaba, Strakowski, and Keck (1999) assessed the legal histories and psychiatric features of 36 males convicted of sexual offences. Psychiatric features were assessed with the use of the Structured Clinical Interview for DSM-IV Axis I Disorders and the Structured Clinical Interview for DSM-IV Axis II Disorders. Paraphilias were diagnosed in 21 subjects who were mostly pedophiles (17 subjects - 81%). Posttraumatic Stress Disorder was diagnosed in 6 (29%) sex offenders with paraphilias that constituted 17% of the whole sample. Borderline Personality Disorder was diagnosed in 15 (42%) sex offenders with 11 (52%) falling into the "with paraphilias" category and four falling into the "without paraphilias" category.

Finally, somatization and hysteria (Conversion Disorder) appear to be related to pathological dissociation. These phenomena are considered by many (Kihlstrom, 1994; Schumaker, 1995; Ross, 1997) as dissociative in nature and "misclassified" as Somatoform Disorders. There also seems to be a direct link between hysteria and elevated hypnotizability. Some research shows that the presence of hysteric symptoms in female patients can be linked to self-hypnotic experiences and good hypnotic skills (Bliss, 1984). However, future research is necessary to determine whether hysteric symptoms in males are associated with higher hypnotizability.

Grossman and Cavanaugh (1990) used the Minnesota Multiphasic Personality Inventory to assess 53 patients accused of having committed sex offenses. Of these 53 alleged offenders, 29 were pedophiles, 17 incest offenders, four exhibitionists, and three were alleged to have engaged in the purchase of illegal child pornography. The most frequent elevation above a T score of 70 occurred in 37% of this subsample on the scale that reflects authority conflicts and antisocial attitudes. The next most frequent clinical scale elevations above 70 occurred in 27% of this subsample on the scales reflecting depressive features and nontraditional sex role interests. Elevations above a T score of 70 on the scales sensitive to hysteria, somatization, and repression occurred in a relatively high percentage of offenders (22%). Such elevations on the scales that reflect concepts associated with dissociation appear to suggest that some of these subgroup subjects may be dissociative.

DISSOCIATION-RELATED PSYCHOPATHOLOGIES IN FEMALE SEX OFFENDERS

The exact incidence of sexual offenses committed by women is unknown, though the literature suggests that such incidence is lower than that for offenses committed by males. Finkelhor and Russell (1984) state that women sexually offend against 5% of all abused girls and 20% of all abused boys. There is a paucity of data concerning female sexual offenders in general. As a consequence, there is a sparse literature that addresses various psychopathologies, and dissociation in particular, in the female sex offender population. Kaplan and Green (1995) compared 11 incarcerated female sexual offenders against children with 11 female offenders incarcerated for nonsexual offences.

The authors compared these two groups with regard to their subjects' own prior sexual and physical victimization experiences and sexual histories. Dissociation pathology was not addressed in this study, though Kaplan and Green (1995) assessed their subjects with regard to post-trauma psychopathology.

It was found that a similar number of women were diagnosed with Posttraumatic Stress Disorder in both groups (8 in the sex offender group and 7 in the nonsex offender group). However, it is difficult to determine from Kaplan and Green's (1995) study whether posttraumatic pathology was due to childhood physical and sexual abuse and whether such pathology was characterized by any dissociative symptoms. In addition, future studies need to assess larger groups of women who sexually offend in order to identify psychopathologies within this group. Mathews, Hunter and Vuz (1997) compared 67 juvenile female sex offenders to a group of 70 juvenile male sex offenders across three parameters: developmental and psychiatric characteristics, history of maltreatment, and sexual perpetration charcateristics. Mathews et al. (1997, p.191) reported that "nearly one-half of the studied females met clinical criteria for the diagnosis of posttraumatic stress disorder." Unfortunately, posttraumatic stress disorder diagnoses were not available for the sample of juvenile male offenders.

PATHOLOGICAL DISSOCIATION IN SEX OFFENDERS: CLINICAL SYMPTOMS

There are various clinical symptoms of dissociation, several of which have been reported as present in some sex offenders. Steinberg (1995) lists amnesia,

depersonalization, derealization, identity confusion, and identity alteration as five major dissociative symptoms considered in most theoretical frameworks. She believes that understanding of these 5 core symptoms is essential to diagnose and assess dissociative disorders adequately because first, the five dissociative disorders can all be defined in terms of different constellations of the five core symptoms, and second, the variety of external manifestations of dissociation, such as flashbacks, out-of-body experiences, and the like can be understood as clinical indicators of the five core symptoms.

Steinberg (1995) regards amnesia as the foundational symptom of the five dissociative symptoms in that it is the "building block" on which the others rest. Amnesia is usually described as "gaps" in the patient's memory, ranging from minutes to years, and is sometimes described as "lost time." Depersonalization manifests in a variety of ways in trauma survivors. Patients report depersonalization in terms of their feeling detached from the self, feeling that the self is strange or unreal, feeling physically separated from part(s) of their body, feeling detached from their emotions, or feeling that they are an automaton or robot. Symptoms of derealization include feelings of estrangement or detachment from the environment, or a sense that the environment is unreal, while identity confusion can be defined as a subjective feeling of uncertainty, puzzlement, or conflict about one's own identity. Identity alteration can be defined as a person's shift in role or identity, which is observable by others through changes in the person's behaviour (e.g., use of different names, possession of a learned skill for which one cannot account, discovery of strange or unfamiliar personal items in one's possession).

Amnesia and consequent denial of the offence, as a consequence, as well as depersonalization and derealization, are the dissociative symptoms reported most frequently by the literature as present in clinical practice with some sex offenders.

CLINICAL SYMPTOMS OF DISSOCIATION IN EMPIRICAL STUDIES

Bourget and Bradford (1995) compared 20 individuals who claimed amnesia for their alleged sexual offenses (all found guilty on legal outcome) with 20 convicted sex offenders who admitted to their offense (admitters), and 20 men who did not admit to their offence (nonadmitters). The aim of the study was to explore the psychopathology of individuals who claim amnesia for their sex offences. Bourget and Bradford (1995) hypothesized that these individuals would display an elevated degree of psychopathology in general and prominent impairment in regard to their sexual functioning. Major differences between groups were found with regard to the use of alcohol at or around the time of the time of the alleged offense. However, Bourget and Bradford (1995) failed to report whether such differences were statistically significant. In general, a high percentage of amnesic individuals (80%) reported such use. A similar report was made by 40% of admitters; in contrast, only 15.8% of the nonadmitters reported the use of alcohol at or around the time of the alleged offense. Moreover, amnesic offenders had used more violence in the perpetration of their offences, in comparison with the other two groups, while the nonadmitters had generally been involved in less violent acts. In addition, "amnesic offenders were more likely than either admitters or nonadmitters to be sexually aggressive or to show rape-proneness" (Bourget and Bradford, 1995, p. 304). It should be noted that the percentage of offenders who claimed amnesia for their offence was relatively small. In general, only

four percent (28 of 707) of the total population of sex offenders, who were assessed for the purpose of this study within a specific time period, claimed amnesia for their offence, while nonadmitters comprised 27% (189 of 707) of such a population.

Bourget and Bradford (1995) believe that sex offenders who claimed amnesia had a distinct profile in comparison with other subgroups of men who offend sexually. The authors suggest exploration of the possible role of dissociative processes at the time of the commission of the crime with respect to amnesia for the offense. Further, Bourget and Bradford (1995) advise several procedures useful in the assessment of dissociative pathology in the population of sex offenders. These procedures are: history taking of previous dissociative or amnesic events with or without substances, eye-roll sign, hypnotic induction profile, and the use of the Dissociative Experiences Scale as a dissociative screening device. Bourget and Bradford (1995) also discuss in their article two essential points with regard to dissociation and offending; first, the relationship between amnesia and alcohol, and second, genuineness of the reported amnesia. These issues are of paramount importance with regard to the diagnosis and assessment of dissociative pathology in sex offending.

Finally, it appears that some men from the subgroup of nonadmitters might also be affected by pathological dissociation. It seems plausible that the denial of the offense in some cases might have been caused by amnesia. It is possible that such cases were classified as non-admitters because amnesia was not clearly articulated by offenders while denial was a prominent feature during the assessment procedure. Therefore, it might be useful in a clinical practice to assess for pathological dissociation not only persons who claim amnesia for their offense but also those who deny their offense.

Grossman and Cavanaugh (1990) found that 23 of 53 of alleged sex offenders from their sample denied having engaged in deviant sexual behavior. Patients in Grossman and Cavanaugh's study (1990) were classified as deniers if they reported that they had never engaged in deviant sexual behavior and as admitters if they reported ever engaging in such behavior. The validity scale scores of the Minnesota Multiphasic Personality Inventory were compared for both groups. In general, the patients who denied deviant sexual behavior showed more evidence of minimizing psychopathology than did those who admitted to deviant sexual behavior. The difference between deniers and admitters was statistically significant for four of the five validity scales assessed, while the fifth scale produced a nearly significant trend in the same direction. Further, deniers showed significantly less psychopathology on several clinical scales of the MMPI, possibly due to their minimizing their psychopathological symptoms.

Grossman and Cavanaugh's (1990) study appears to have two relevant findings with regard to dissociative pathology in persons who sexually offend. First, it acknowledges the presence, in some patients, of denial of the offense, which may be a consequence of dissociative amnesia. However, the validity of such a conclusion needs to be verified by means of the psychometric assessment of dissociation in future research and clinical practice with sex offenders. Second, the outcome of the study suggests that amongst persons who sexually offend, deniers may be especially prone to minimize their psychopathology. Therefore, difficulties with assessing symptoms of any psychopathology, including those typical for pathological dissociation or posttraumatic stress disorder, might be an obvious consequence of such minimization.

Kaplan and Green's study (1995) was discussed in one of the previous sections in greater detail with regards to the prevalence of dissociative pathology in female sexual offenders. These authors also commented on the denial of the offense amongst their subjects: three of 11 female offenders from their sample denied their offenses.

However, amnesia has also been reported to be present in other than sex-related criminal offenses. Taylor and Kopelman (1984) found amnesia in 10.3% of 203 cases of violent and non-violent crime. A group of amnesic offenders comprised 9 persons convicted for murder/manslaughter, 6 for personal violence, and four for criminal damage. Taylor and Kopelman (1984, p.586) conclude that "amnesia may be associated with crimes of violence, particularly with criminal homicide." The authors also discuss possible ways in which amnesia for offenses can arise, such as the pharmacological effects of alcohol, a psychotic mental state, and a psychological defense mechanism. The latter was described by Taylor and Kopelman (1984, p.587) as

> repression or suppression, against recognizing a terrible, fatal and unplanned outburst of violence against someone with whom there had been an intense emotional involvement.

However, Taylor and Kopelman (1984) also acknowledge that "one of the other" psychological defenses such as dissociation may be a prominent mechanism that accounts for amnesia for criminal offences. O'Connell (1960) also reports the presence of amnesia associated with major crime. He found that 20 of 50 persons, convicted of murder, claimed complete or partial amnesia for the crime. O'Connell (1960) suggests that once the possible contribution of alcoholic intoxication is excluded, amnesia for a

criminal act is likely to be of psychogenic rather than organic origin. However, O'Connell (1960, p.275) believes that the active process of repression plays a significant role in only a few cases of amnesia, while a majority of amnesics deal with their problem by "isolating and ignoring the experience - a passive disregard rather than a refusal to recognize."

Even much earlier research appears to emphasize the role of amnesia in crime. Hopwood and Snell (1933), for example, examined 100 male inmates who claimed amnesia for their offences and diagnosed 78 cases as genuine amnesics, 14 as malingerers, and 8 as doubtful. Of the 78 whose amnesia was perceived as genuine, 30 have gradually recovered the lost memory. Hopwood and Snell's (1933) sample comprised 71 men convicted for murder, 19 persons for attempted murder or wounding, 6 for indecency, two for arson, and two for acquisitive crime. The authors suggest that amnesia for crime can be caused by dissociation, in addition to the failure of association and repression. Hopwood and Snell (1933) suggest that the criminal act can be committed in a dissociated state that can account for total and permanent amnesia in some subjects. However, Hopwood and Snell (1933) also discuss repression as a possible cause of amnesia and clearly explain how it differs from dissociation. It is assumed that, in the case of repression, the patient was aware of his actions at the time of committing the crime, and repression took place after the offense in order to deal with the painful memory of the crime. Hopwood and Snell's (1933) study is characterized by sound methodology and interesting and theory-driven discussion of their outcome.

DISSOCIATION IN PERSONS WHO SEXUALLY OFFEND: CLINICAL PRACTICE AND CASE STUDIES

Evidence of dissociative pathology or single dissociative symptoms in persons who sexually offend also has been reported outside empirical psychological research. Some of that evidence comes in the descriptive form of case studies or general comments and statements of professionals who have great clinical experience in working with sex offenders. Such evidence cannot be disregarded despite the lack of empirical support; quite the opposite, it should be carefully analyzed as it can generate future, controlled studies testing the hypothesis of elevated dissociation in persons who sexually offend.

Graham (1993), for example, states that offenders who commit violent sexual assault demonstrate more severe dissociation, and as a consequence they often do not remember considerable portions of the assault. Bliss and Larson (1985, p.523) reported that some of the sexual offenders who took part in their study described possible dissociations at the time of the crime as follows: "Like a dream; a haze over everything, can't remember all - felt compelled"; "like a fantasy - a weird feeling of unreality"; "floating feeling, not real, a third party watching"; "couldn't believe I was doing it"; "sitting back watching, saying it wasn't happening." Past possible dissociative experiences reported by Bliss and Larson's (1985) subjects included amnesias, déjà vu phenomena, no pain when beaten as a child, no pain with dental procedures, extrasensory experiences, visions, voices, micropsia, macropsia, and out-of-body experiences.

Dwyer, Rosser and Sawyer (1992) reported the case of the 28-year-old man convicted of exposing. He described spending long periods of time (4-6 hours) in seeking out a victim and also reported loss of time reference, and "memory loss" that had been the source of many arguments with his spouse. Ross (1994) reported a similar case where a young man in his early twenties, Jim, convicted of indecent exposure, claimed complete amnesia for all the indecent exposures, though did not deny his guilt. The client did not report any physical, sexual, or emotional abuse in childhood and had no other criminal record.

Ross (1994) utilized hypnosis and successfully recovered his client's memories. This outcome of the hypnotic session resulted in the client feeling disappointed, upset and ashamed. However, he also appeared to be motivated to commence therapy regarding his offensive behavior. Ross (1994, p.253) states that: "Jim's was a simple and easily treated dissociative disorder. His diagnoses were psychogenic amnesia and exhibitionism." It seems that Ross (1994) has a right to be so firmly convinced about the accuracy and correctness of his diagnosis as he excluded a possibility of organic amnesia or amnesia related to alcohol and drugs. Moreover, he was able to check the credibility of his patient's hypnotic "confession" by comparing its details with police records.

Finally, Saradjian (1996) reports two cases of women, amongst 50 females interviewed by her, who abused a child "while in a dissociative state." The author elaborated on the case of Sylvia who claimed total amnesia regarding her offending. According to Saradjian (1996, p.156), Sylvia "appeared to be genuinely shocked at her daughters' disclosures of her sexual and physical abuse of them" and seemed to be very open with

the child protection team. The presence of physical and behavioral indicators of Sylvia sexually and physically abusing her children fully confirmed her daughters' clear and consistent disclosures. Moreover, Sylvia's hospital files suggested that she, possibly, was severely physically and sexually abused as a child. In addition, Sylvia had a history of amnesia that was seriously affecting her life, noticed for the first time during her school years. Unfortunately, Saradjian (1996) commented neither on Sylvia's use of alcohol and drugs nor the results of the physical examination that are necessary to exclude non-psychogenic sources of the patient's amnesia. However, Sylvia's long history of amnesic problems and childhood abuse seems to warrant a diagnosis of dissociative pathology, with amnesia as its main symptom.

DISSOCIATION IN SEX OFFENDERS: CONCLUSIONS

In general, there is some convincing empirical evidence in the rather sparse psychological literature of elevated levels of dissociation in men who sexually offend. All cited studies, except one (Dwyer et al., 1992) found that sex offenders have a higher level of dissociation in comparison with the normal population. One study also found higher dissociative scores in men who offend sexually than those in non-sex offenders (Graham, 1993). Several studies presented in this chapter were flawed by various shortcomings. Therefore, future research that addresses the issue of pathological dissociation in persons who sexually offend should utilize appropriate methodological designs. In addition, it seems such research, in the assessment of dissociation, would profit immensely from the employment of recently developed psychometric measures of

dissociation such as the Dissociative Experiences Scale-II or the Structured Clinical Interview for DSM-IV Dissociative Disorders.

The prevalence of psychological disorders that are linked to pathological dissociation, either by virtue of similar etiology or the presence of dissociative symptoms in their diagnostic criteria, appears to confirm a hypothesis of the presence of dissociation in the population of sex offenders. However, studies that indicate the existence of dissociation-related pathologies such as Borderline Personality Disorder or Posttraumatic Stress Disorder in sex offenders fail to show that the prevalence of these disorders is higher than in other groups of offenders. This seems to be particularly true for sex and non-sex female offenders where rates of Posttraumatic Stress Disorder for both groups are rather similar. Therefore, it is difficult to conclude that the prevalence of dissociation-related pathologies is sex offender-specific as it could also be a characteristic phenomenon for other groups of offenders, for example, violent offenders.

It appears that the literature most often cites amnesia for the offense as a dissociative symptom in the group of persons who sexually abuse. However, some studies also suggest that besides clearly stated amnesia for the offense, denial of the offense can also indicate the presence of dissociative pathology. Rates of amnesia and denial of the offense amongst sex offenders appear to vary depending on a particular study and chosen methodology. In addition, amnesia for the offense has also been found amongst non-sex offenders, and the rates of such amnesia vary from 10.3% to 40%. None of the studies cited above compared rates of amnesia or denial of the offense between sex and non-sex offenders. Therefore, it seems that amnesia as a dissociative symptom and its

consequence such as denial for the offense, are not exclusively characteristic for the population of persons who sexually offend.

In addition, two issues with regard to the assessment of amnesia for the offense as a dissociative symptom have to be taken into account. These are: the use of alcohol at or around the time of the offense and a possibility of malingering. Therefore, it seems that assessing for dissociative symptoms other than amnesia, and the use of various assessment tools, are advisable in determining the presence of dissociative pathology in sex offenders.

Finally, the presence of dissociative symptoms such as amnesia, depersonalization or derealization in the group of sex offenders is suggested in an anecdotal form by professionals working with this population. Such material obviously lacks "statistically-derived objectivity", but it appears to be extremely valuable as an indication rather than a proof of pathological dissociation in persons who sexually offend.

CHAPTER III

CHILDHOOD SEXUAL AND PHYSICAL ABUSE IN THE ETIOLOGY OF PATHOLOGICAL DISSOCIATION

This chapter will discuss the relationship between childhood abuse, and the development of pathological dissociation in persons who experienced such abuse. According to Coons, Cole, Pellow and Millstein (1990) child abuse can be divided into sexual abuse, physical abuse, emotional abuse, and neglect. Sexual abuse can be subdivided into incestuous and nonincestuous types, depending on the relationship of the perpetrator to the victim.

The issue of childhood abuse as the chief etiological factor in the development of adulthood pathological dissociation will be discussed here in the context of the general population. In addition, the psychological literature that addresses childhood abuse amongst persons who sexually offend will be critically discussed. Unfortunately, there is very sparse psychological research that addresses simultaneously issues of childhood trauma and adulthood dissociation in sex offenders. Therefore, by analogy to the general population, it will be proposed that the presence of childhood trauma amongst sex

offenders may also lead to pathological dissociation. In general, the main aim of this chapter is to test the hypothesis that increased childhood sexual, physical and emotional abuse in the sex offender population may be a prominent pathway in the development of pathological dissociation in this group. However, the author of this thesis does not take a stand regarding the etiological role of childhood abuse in sex offending. There is a rich body of psychological literature that discusses this issue in great detail.

Various forms of childhood, adolescence and adulthood pathological dissociation appear to represent only a small fraction of a broad array of severe psychopathology that can follow childhood sexual, physical and emotional abuse (Briere and Runtz, 1988). A list of such psychological dysfunctions in adulthood as sequelae of incest or other sexual abuse includes: depression, guilt, self-blame, poor self-esteem, feelings of inferiority later in life, significant interpersonal problems, fear of men, transient and/or negative relationships, repeated victimization, delinquency, "promiscuity" or compulsive sexual behavior, sexual dysfunction, increased risk of suicide, self-mutilation, alcohol and drug dependence. However, some research on the effects of childhood trauma either consists of summarized case reports, or is flawed by methodological problems (Briere and Runtz, 1988). It is beyond the scope of this thesis to discuss the reliability of such research. However, brief information on the effects of childhood trauma was included above in order to indicate that such trauma is associated, according to the majority of the published studies, with subsequent psychological dysfunction in adulthood. Pathological dissociation, which is of interest here, is only one example of such dysfunction.

PATHOLOGICAL DISSOCIATION AS SEQUELAE OF CHILDHOOD ABUSE: GENERAL POPULATION

There is a rich body of literature that deals with "dissociative consequences" of childhood sexual, physical and emotional abuse. It appears that there are two different types of study that link childhood abuse with consequent pathological dissociation. The first type of research analyzes the prevalence of various psychopathologies, including dissociative disorders, in children or adult victims of childhood trauma. Second type studies investigate rates of child sexual and other type of abuse amongst patients who suffer from dissociative disorders. In general, these two different angles in research on the effects of sexual abuse both appear to lead to better understanding of the childhood trauma-adulthood dissociative pathology link.

Hornstein (1996), for example, found a high prevalence of childhood trauma amongst her subjects - 64 children with dissociative disorders (44 with DID and 20 with Dissociative Disorder Not Otherwise Specified (DDNOS)). In children diagnosed with DID, over 80% had documented histories of sexual abuse, while 60% of these children experienced both sexual and physical abuse. In addition, documentation of neglect was available in 80% of cases. Hornstein (1996) states that percentages were only slightly lower in those cases with DDNOS. Finally, she found that over 70% of the children witnessed family violence. In a similar vein, Coons, Bowman, Pellow and Schneider (1989) attempted to identify the prevalence of childhood and adult traumatization in DID and PTSD patients, and other DSM-III diagnostic groups. Their experimental group consisted of 43 male and 97 female psychiatric patients. Subjects were diagnosed according to the DSM-III criteria. In addition to the clinical assessment, the Dissociative Experiences Scale and a trauma questionnaire were administered to all

patients. The DID diagnosis was assigned to 20 patients while 11 patients were diagnosed with psychogenic amnesia, 6 with atypical dissociative disorder, and 13 with borderline personality disorder.

It was found that rates of childhood sexual and physical abuse in different groups were as follows: 80% and 45% in DID patients; 67% and 50% in atypical dissociative disorder patients; 27% and 27% in patients with psychogenic amnesia; 57% and 14% in PTSD patients (females); and 31% and 38% in borderline personality patients respectively. None of the male PTSD patients reported either sexual or physical child abuse. An analysis of DES mean scores and dissociative symptoms (%) across different diagnostic categories showed that DID patients obtained the highest values (42.5 and 61% respectively), followed by atypical dissociative disorder patients (38.3 and 59%). Other diagnostic groups obtained the following values: 32.7 and 48% (PTSD -females); 26.2 and 43% (psychogenic amnesia); and 23.6 and 33% (PTSD -males).

In addition, Coons et al. (1989) found that their patients with dissociative disorders had increased rates of rape and wife battery in adulthood compared with other diagnostic groups. This study appears to confirm a strong association between child abuse and consequent adult pathological dissociation. Coons et al. (1989) attempted to validate such an association across both genders by employing male subjects.

Goodwin and Sachs (1996) investigated the rates of childhood abuse amongst patients with Dissociative Identity Disorder (DID) in several studies and found that 97% of patients with DID reported some history of abuse during childhood. Kluft (1984) describes how the abused child might feel in the traumatic situation. The child-victim may 1) fear for his/her own life; 2) fear for the life of a loved person; 3) be in a state of

blurred consciousness due to fatigue, pain, illness, or substance ingestion; 4) experience some sort of moral confusion, at times related to secrecy or actual "brainwashing"; 5) have no available support.

Goodwin and Sachs (1996) suggest, similarly to Briere and Runtz (1988), that abused children would develop dissociative strategies as a response to trauma. It seems that continuous abuse may result in repeated dissociation and consequently in the development of "well learnt" maladaptive dissociative skills. In addition, the more severe the abuse, the higher the patient's score on measures of dissociation (DiTomasso and Routh, 1993). However, Goodwin and Sachs (1996, p.94) state that "not all victims, however, even of the most severe child abuse, develop dissociative disorders." This phenomenon is explained by Goodwin and Sachs (1996) by wide constitutional differences in the ability to dissociate. A biological explanation proposed by the authors appears to be slightly simplistic. It also seems plausible that some environmental resilience factors can play a role in reducing or blocking the development of dissociation in some victims of sexual trauma.

Briere and Runtz (1988) compared 86 non-abused and 67 abused women with regards to psychological symptomatology measured by the Crisis Symptom Checklist (CSC). Sexual abuse in this study was defined as any self-reported sexual contact (e.g., fondling to intercourse) experienced by a client before the age of 15, initiated by someone five or more years her senior. In general, it was found that the abused group scored significantly higher on measures of dissociation. Statistically significant

differences were found on measures of "spacing out," derealization and out of body experiences. However, no differences were found with regard to dizziness and fainting.

Briere and Runtz (1988) hypothesized that dissociation amongst adults who were sexually abused as children could have functioned initially as a coping technique and later became an autonomous symptom. This study appears to signal in a clear way that childhood trauma is an important etiological factor in pathological dissociation.

Coons, Cole, Pellow and Milstein (1990) compared the incidence of symptoms of posttraumatic stress and dissociation in women victims of child abuse, rape, and wife battery with the incidence of such symptoms in a control group of bulimic women. Posttraumatic stress symptoms (10 items) and dissociation symptoms (10 items) were screened for and measured by the questionnaire developed at the Julian Center, a women's counseling clinic. The study group and control group differed with regard to the incidence of abuse in that 56% of the study group reported sexual abuse and 33% women reported physical abuse. In contrast, 10% of the subjects from the control group reported childhood sexual traumatization and 10% childhood physical abuse. With regard to dissociation, statistically significant differences between the groups were found only in regard to depersonalization and inner voices. It is possible that relatively weak differences on dissociative measures between abused and bulimic subjects were partially due to the possibly low reliability of the questionnaire employed and the nature (bulimic patients) of the control group. The first shortcoming of the study was acknowledged by Coons et al. (1990) while a choice of the bulimic patients as controls was explained by exploration of sexual abuse/eating disorders relationship.

Ellason and Ross (1997) explored an association between reported childhood abuse and psychotic and other symptoms. They administered the Symptom Checklist 90-Revised, the Dissociative Experiences Scale (DES), and the Dissociative Disorders Interview Schedule (DDIS) to 144 psychiatric inpatients who reported childhood physical or sexual trauma. All correlations of trauma items and symptoms of dissociation were found to be significant. The correlation coefficients of trauma items and symptoms on the DES were: .40 for the number of perpetrators of physical abuse; .42 for the number of perpetrators of sexual abuse; and .46 for the number of types of sexual abuse. The correlation coefficients of trauma items and the conversion/hysteria symptoms on the DDIS were .54, .47, and .44 respectively.

There is a body of research that explores in greater detail variables that modulate the association between trauma and dissociative pathology. Kirby, Chu and Dill (1993), for example, indicated important variables such as severity and age of onset of sexual abuse. It was found that female subjects with more severe sexual abuse reported significantly more dissociative experiences than those with a history of less severe forms of sexual abuse. In addition, Kirby et al. (1993) reported an inverse correlation between age of onset of sexual abuse and degree of dissociative experiences.

Zlotnick, Begin, Shea, Pearlstein, Simpson and Costello (1994) explored a trauma-dissociation relationship from a different angle in that they examined the relative association of sexual abuse features with the degree of dissociative experiences in a clinical sample of 56 women. All women from Zlotnick et al.'s (1994) sample reported severe childhood sexual abuse and physical abuse and their dissociative symptoms were assessed by the Dissociative Experiences Scale. It was found that a reported history of sexual revictimization by a greater number of offenders (four or

more) is significantly related to a higher level of adult dissociative experiences. In addition, the average score on the DES for the subjects of this study was very high (31), though Zlotnick et al. (1994) failed to employ a comparison group that would define the statistical significance of such a score. In comparison, DES scores in the normal population range are between 10 and 20 (Ross, 1996).

Zlotnick et al.'s (1994) study takes a microanalytic approach toward
a trauma-dissociation link in that it addresses an important correlate of this link such as revictimization. Moreover, the authors argue convincingly for adult trauma as yet another pathway to dissociation. In addition, Zlotnick et al.(1994) discuss factors that might alter the severity of trauma-related dissociation, such as positive childhood experiences after childhood trauma.

A similar approach to the childhood trauma/adulthood dissociation link was taken by Maynes and Feinauer (1994). They tried to determine a possible relationship(s) between the effects of variables such as identity of perpetrator; frequency; duration and severity of childhood sexual abuse, and adult symptomatology of acute dissociation; chronic dissociation; and somatized anxiety. Acute dissociation (that took place at the time of the sexually abusive act) was measured by the Acute Dissociation Scale, while chronic dissociation was measured using a subscale of the Trauma Symptom Checklist-33. Maynes and Feinauer (1994) found that only severity of sexual abuse was highly correlated with dissociation and somatized anxiety. This finding is consistent with other research addressing this issue. In addition, it is relevant with regard to the treatment of pathological dissociation in that patients with a history of severe child abuse should be assessed for the potential presence of dissociative symptoms.

A confirmation of the association between childhood trauma and pathological dissociation in children and adolescents was found by Coons (1994). Diagnoses were made on the basis of an extensive psychiatric evaluation. The Dissociative Experiences Scale and the Structured Clinical Interview for Dissociative Disorders were employed additionally with adolescents to facilitate the screening and diagnosis. Of 31 children (25 females and 6 males), 9 met the criteria for Multiple Personality Disorder (MPD) and 10 for Dissociative Disorder Not Otherwise Specified (DDNOS). All MPD patients reported either physical (89%) or sexual abuse (89%) while only one patient of 19 DDNOS subjects reported no child abuse. Coons' (1994) study appears to provide extremely valid evidence of the abuse-dissociation correlation because of the close proximity in age to when the abuse reportedly occurred. This in turn allowed the author to confirm child abuse through collateral sources.

Most of the research that explores the childhood abuse/adulthood dissociation link appears to concentrate on sexual abuse. Other types of abuse, for example physical or emotional, are addressed in such research relatively rarely or are completely omitted. Irwin (1994) analyzed dissociative experiences in adulthood in relation to a *broad* measure of childhood trauma. He assessed 152 mature psychology students for dissociation using the Questionnaire of Experiences of Dissociation (QED) and for childhood trauma using the Survey of Traumatic Childhood Events (STCE). The latter instrument taps childhood trauma of 11 types: intrafamilial sexual abuse, extrafamilial sexual abuse, intrafamilial physical abuse, loss related to a friend, loss related to the family, isolation, personal illness or accident, parental divorce/separation, assault, loss of the home, and robbery. Standard regression analysis revealed three predictors of dissociation: intrafamilial sexual abuse, extrafamilial sexual abuse, and familial loss in

childhood. A death in the family and the hospitalization of a family member were identified by post hoc analyses of the individual items of the "childhood loss" subscale as two specific aspects of loss related to QED scores.

Irwin's (1994) findings appear to be extremely interesting in that another type of trauma, childhood loss, was identified as a predictor of dissociation in adulthood. However, these findings should be interpreted with caution as Irwin (1994) utilized psychometric instruments that require further validation. The author also suggests that yet other types of childhood trauma (for example emotional abuse) or nonpathological factors (for example, parental encouragement of imaginative activities in childhood) may contribute to the development of dissociative defenses. The latter suggestion is especially interesting as current theories of dissociation, especially those that explain its etiology, do not account for pathological dissociation in persons who have not experienced childhood trauma.

It seems that Ross's (1997) model of the incestuous childhood abuse etiology of Dissociative Identity Disorder (DID) provides an adequate explanation of the abuse pathway in the development of dissociative psychopathology. He discusses the rise of dissociation in this pathway with regard to attachment of the abused child to the perpetrator. Ross (1997, p.284) assumes that the abused child "feels trapped, helpless, and overwhelmed." Despite all these feelings the child "must attach to her perpetrator." Such an attachment to the child's primary caretaker seems to be a biologically driven imperative as the child is biologically dependent on adult caretakers for physical survival. In addition, Ross (1997, p.284) states:

> More than that, the child has no choice spiritually or emotionally - she must love her parents, and must want to be loved by them. The child cannot exercise an option of no love.

The child in an abusive family, according to Ross (1997), must love the people who hurt her/him, or die. Therefore, he believes that the need for the abused child to keep her/his attachment systems up and running is the core problem in DID, and the primary driver of the dissociation. As a consequence, Ross (1997) says, the modules of the mind that maintain attachment must be disconnected from those taking in the traumatic information from the outside world. Such a disconnection can be achieved by permanent trance, depersonalization, or catatonia; briefly, by means of dissociation. Another means of dissociation utilized by the abused child might be, particularly in a case of DID, the creation of new realities and new personality states.

One can question the generalizability of Ross' (1997) model as he addresses incest abuse only. However, some current research (Braun, 1990) suggests that 60% or more of DID patients were sexually abused by a father and 23% by a mother. Moreover, Ross (1997) discusses only DID in his model, rather than the whole array of dissociative pathology. However, the same author (1996) proposes a concept in which dissociative phenomena lie on a continuum. Therefore, it seems that such a model might be adequate for other than DID dissociative disorders.

Finally, a relationship between higher hypnotic susceptibility and severity of childhood punishment was explored by Nash and Lynn (1986). Previous research (Hilgard, 1979) suggested that a history of severe physical punishment by parents is moderately

associated with hypnotizability. Nash and Lynn (1986) compared the hypnotic susceptibility of three groups of subjects (396 undergraduate students): an abused group (physical abuse before age ten); a family disruption group (parental divorce or death of parent before age ten and no abuse); and a control group (no physical abuse or family disruption before age ten).

Hypnotic susceptibility of the subjects was assessed using The Harvard Group Scale of Hypnotic Susceptibility, Form A of Sore and Orne. It was found that there were significant differences between the abused group and the control group, and between the abused group and the family disruption group with respect to the distribution of hypnotizability scores. However, the difference between hypnotizability scores for the family disruption group and the control group were not statistically significant. Over 65% of abused subjects were highly hypnotizable compared with 35% of control, and 15% of family-disruption subjects. Despite several shortcomings of the study, for example a specific pool of subjects, Nash and Lynn's (1986) results confirm the abuse-hypnotizability link suggested by other research.

There are also some studies that suggest an association between symptoms of Posttraumatic Stress Disorder (PTSD) and hypnotizability. Stutman and Bliss (1985) divided 26 Vietnam combat veterans into high and low groups on the basis of posttraumatic symptoms. Their subjects with high symptoms were found to be significantly more hypnotizable on the Standford Hypnotic Susceptibility Scale, Form C, than those with low symptoms. Spiegel, Hunt and Dondershine (1988) compared the hypnotizability of 65 patients diagnosed with PTSD according to the DSM-III criteria with that of four other patient samples. The Hypnotic Induction Profile scores of the

PTSD patients were found to be significantly higher than those of all the patient groups studied and a non-patient control group.

PREVALENCE OF CHILDHOOD ABUSE IN THE SEX OFFENDER POPULATION

The psychological research addresses in great detail the issue of childhood trauma in male and female sex offenders. The rates of childhood trauma in this population vary greatly depending on the study. However, the research in general appears to indicate that the prevalence of childhood abuse amongst persons who sexually offend is greater than that of the general population. However, there are not many studies that address concurrently both issues: childhood abuse and consequent adulthood dissociation amongst persons who sexually offend. It seems plausible that in the sex offender population, similarly to the general population, childhood trauma might be one of the main etiological factors in the development of adulthood dissociation.

Ellason and Ross' (1999) study was cited previously in the chapter dedicated to the presence of pathological dissociation in the sex offender population. Their research appears to be one of the few studies available in psychological literature that addresses dissociation in male sex offenders in relation to childhood trauma. Ellason and Ross (1999) compared 14 male sex offenders with 97 adult inpatients receiving treatment for childhood sexual trauma with respect to dissociative symptoms and characteristics of childhood trauma. The rates of physical and sexual abuse amongst sex offenders were relatively high, in that 11 reported a history of physical abuse and 11 a history of sexual

abuse. All subjects reported either or both physical and sexual abuse. At the same time, dissociative disorders were diagnosed by structured interview in 77% of the sex offenders and 92% of the sexual trauma inpatients. Distribution of frequency of various dissociative disorders in both groups differed (higher in the sex offender group), except for Dissociative Identity Disorder, though Ellason and Ross (1999) did not conduct a statistical analysis. It appears that rates of both childhood trauma and dissociative disorders in the group of sex offenders are relatively high.

However, it seems very difficult to conclude from Ellason and Ross' (1999) results that there is an association between childhood trauma and dissociative scores without employing a proper control group (for example a group of sex offenders without a history of childhood trauma). In general, one can intuitively assume that there are strong similarities between the two groups from Ross and Ellason's (1999) study, though the statistical means would be necessary to change this assumption into a feasible scientific statement.

Graham's (1996) study also explores relatively directly whether there is an association between childhood abuse and adulthood dissociation in persons who sexually offend. He compared various groups of sex offenders (286) with respect to the type of abuse (physical, sexual, both, or none), gender of the abuser (male, female, both sexes), relationship of the abuser to the victim (mother, father), and their scores on alienation, dissociation, and social desirability measures. Graham's (1996) groups were created on the basis of the type of offence (abuse) committed by their subjects. These groups were: incest/natural father (71); incest/stepfather/relative (74); rape (63); and pedophile (78).

The Dissociative Experiences Scale was utilized to measure dissociation in the subgroups of sex offenders.

Graham (1996) did not find significant differences in the levels of reported abuse between his groups. However, in general the level of reported sexual abuse was found to be relatively high, in that over 70% of sex offenders reported sexual abuse and 50% claimed physical abuse. In addition, the subjects who were physically abused by both parents had a higher level of dissociation than the groups abused by either the father or mother alone. Graham's (1996) findings, based on the sample of sex offenders, appear to confirm a strong association between the severity of childhood abuse and the level of dissociation in adulthood found in the general population. However, Graham's (1996) research tends to indicate that physical abuse in particular is an important source of pathological dissociation in adulthood of sex offenders. This finding is slightly different from the general population as the literature emphasizes mostly sexual abuse as an etiological factor in dissociation amongst non-offenders.

An outcome of Graham's (1996) study coincides with research by Briggs and Hawkins (1996) which suggests that sex offenders may have been more accepting of their childhood sexual abuse than non-offenders. Therefore, a strong role of childhood sexual abuse in the development of pathological dissociation amongst persons who sexually offend may be questioned. According to Briggs and Hawkins (1996), 88% of convicted male child molesters (84), in comparison with 68% of non-offenders reported that they did not understand or accept that abuse was aberrant behavior but rather thought that it was a commonplace, inevitable, and consequently a normal part of childhood. Moreover, 69% of the sex offenders liked some aspect of the initial abuse.

The results of this study do not obviously prove that dissociative mechanisms did not take place in offenders who were sexually abused as children. However, such results suggest that other than sexual types of trauma may serve as important pathways in the development of adulthood pathological dissociation in the sex offender population.

Weeks and Widom (1998) assessed with the use of self-report in 301 convicted adult male felons for a wide spectrum of childhood victimization such as physical abuse, sexual abuse, and neglect. Weeks and Widom's (1998) sample comprised 38 (13%) sex offenders. The extent of self-reported childhood physical abuse, sexual abuse, and childhood neglect amongst these men was respectively 65.8%; 26.3%, and 18.4%. Rates of self-reported childhood neglect and physical abuse did not differ significantly between the sex and non-sex offenders, while the rate of childhood sexual abuse amongst the sex offenders (26.3%) was significantly higher than in the non-sex offenders group (12.5%). Weeks and Widom (1998) suggest that sequelae of childhood victimization, for example symptoms of posttraumatic stress, should be addressed in treatment programs for inmates.

It seems that childhood trauma *per se* should also be targeted in therapy for prisoners. Such a stand appears to be in line with findings that having a history of childhood victimization has an impact on the efficacy of short-term mental health treatment programs (Holmes, 1995). Issues regarding addressing childhood trauma in therapy for persons who sexually offend will be discussed in the chapter that deals with therapeutic implications of childhood trauma and pathological dissociation in this population.

Childhood sexual abuse amongst sex offenders has been addressed by psychological literature with particular interest because of the abundance of theories that postulate a strong etiological role of childhood sexual abuse in sex offending. However, only one paper that reviews the empirical literature on the proportion of child sexual abusers who were themselves sexually victimized as children will be discussed here.

Hanson and Slater (1988) found that 28.2% of 1,717 offenders reported that they had been sexually abused as children. In addition, it was found that the rate of sexual victimization among offenders against boys (34.6%) was nearly twice as high as that for offenders against girls (18.2%). Hanson and Slater (1988) state that such a rate is higher than the rate found in the male general population (10%). However, the authors caution that the significance of the relatively high rate of sexual victimization for child sexual abusers remains unclear. This is due to questionable reliability of the retrospective self-report procedures used in all the studies and possible over- or under-reporting of childhood victimization by perpetrators.

Seghorn, Prentky, and Boucher's research (1987) addressed both physical and sexual abuse in 97 incarcerated rapists and 54 child molesters. They found that the incidence of sexual assault in childhood among child molesters was 57%, while the incidence for rapists from their sample was 23%. The incidence of child neglect was 55% for rapists and 59% for child molesters, while incidence of physical abuse was found to be 58% and 57% respectively. Seghorn et al.'s (1987) results appear to indicate that there are differences between various subgroups of sex offenders with regard to rates of abuse. Moreover, the rates found by Seghorn et al. (1987) appear to be higher than those cited by Hanson and Slater (1988) or other psychological literature.

Generally, rates of abuse in childhood and adulthood for incarcerated women offenders are relatively high. Singer, Bussey, Song, and Lunghofer (1995), for example, found that 81% of their 201 subjects (randomly selected female inmates) reported having being sexually victimized as children and/or as adults.

Similarly, the incidence of childhood trauma in the group of female sex offenders is significant and seems to be higher than that in the group of men who sexually offend. Mathews, Hunter and Vuz (1997) compared 67 juvenile female sex offenders with 70 juvenile male sex offenders with respect to several parameters, including history of sexual victimization. It was found that 77.6% of female sex offenders reported a history of sexual abuse while 60.0% of these women had a history of physical abuse. The incidence of both types of abuse was lower for men sex offenders in that 44.3% reported a history of sexual abuse and 44.9% had a history of physical abuse. In addition, the juvenile female perpetrators tended to have experienced more severe victimization, as evidenced by a higher average number of molesters, a younger age at first victimization, and the more frequent report of having been subjected to offender aggression. However, differences in these parameters between male and female subjects were not statistically significant. Mathews et al.'s (1997) study indicates that not only are rates of childhood trauma amongst female sex offenders higher than those in the male sex offenders group, but also women who sexually offend might have experienced more severe childhood victimization.

Kaplan and Green (1995) compared 11 incarcerated female sex offenders with 11 female non-sex offenders with regard to their own sexual and physical victimization

experiences. It was found that 9 of 11 women who sexually offend were sexually abused during their childhood and 8 experienced childhood physical abuse. By comparison, 5 of the 11 non-sex offender females reported childhood sexual abuse and 5 had a history of childhood physical abuse. Unfortunately, Kaplan and Green (1995) did not report whether differences in frequency of abuse between groups are statistically significant. In addition, the small size of both groups appears to be a major shortcoming of this study.

There are other studies that attempt to explore a difference between sex offenders and non-sex offenders with respect to the incidence of childhood trauma. Such an approach appears to have aims that relate closely to the etiology of sex offending. Two of these studies are reviewed here in order to explore the relationship between the incidence of childhood victimization in the population of sex offenders and dissociative pathology, rather than to support any etiological claims in the area of sex offending.

Haapasalo and Kankkonen (1997), for example, compared childhood abuse experiences of 16 sex offenders and 16 violent offenders using the Family-of-Origin Scale. In general, sex offenders reported significantly more psychological abuse, in particular verbal abuse, than did the violent offenders. However, the groups did not differ from each other with regard to reported physical and sexual childhood abuse experiences.

Benoit and Kennedy (1992) compared the incidence of sexual and physical victimization between different subgroups of 100 adolescent inmates (two groups of child molesters, a violent group, and a non-violent group). No statistical differences were found between these groups with respect to frequency or intensity of childhood

sexual or physical victimization. However, 26% of the child molesters in this study had been sexually victimized, while the incidence of physical childhood abuse in all four groups ranged from 32 to 48% in each group. Further, Benoit and Kennedy (1992) found that 40% of the combined molester groups had been physically victimized while 44% of the combined aggressive and non-aggressive groups underwent similar type of abuse. This study does not seem to suggest that rates of childhood abuse amongst sex offenders are higher than those in other groups of offenders. However, percentages of abuse in male sex offenders appear to be very high compared with those of the general population.

CHILDHOOD ABUSE AND CONSEQUENT ADULTHOOD PATHOLOGICAL DISSOCIATION: CONCLUSIONS

The psychological literature acknowledges detrimental consequences of childhood trauma on psychological functioning in adulthood. Dissociative pathology appears to be one such consequence. The research that addresses links between childhood victimization and subsequent dissociative pathology in the general population seems to confirm the hypothesis of a strong association between childhood abuse and adulthood dissociation.

On the one hand, studies that explore the incidence of childhood abuse amongst child and adult patients with dissociative disorders report such incidence at a very high level in this population. Rates of sexual abuse appear to be higher than those of other types of abuse. In addition, such rates appear to vary with respect to the type of dissociative

disorder. However, in general, the incidence of childhood abuse in the patients with dissociative disorders is higher than that in the general population. Moreover, it seems that continuous abuse in particular may contribute to the development of maladaptive dissociative skills. In addition, several studies also suggest that the more severe the abuse in the childhood, the higher the person's dissociative scores. The age of onset of sexual abuse, history of sexual revictimization and number of abusers seem to be yet more variables that modulate the association between childhood trauma and subsequent dissociation. On the other hand, the research that addresses pathological dissociation in persons who were abused as children shows that such persons score higher on dissociative measures than persons who were not abused.

It appears that besides sexual and physical abuse, other various types of childhood trauma may also contribute to the development of pathological dissociation, though research that explores this issue is sparse. Some studies identified, for example, emotional abuse and familial loss as types of trauma contributing to consequent adulthood dissociation. Ross' (1997) model of the development of Dissociative Identity Disorder (DID) as a result of incestuous childhood abuse was summarized. This model appears to explain adequately the link between incestuous childhood sexual abuse and later pathological dissociation, not necessarily DID. Finally, some literature indicates an association between childhood physical abuse in particular, and hypnotizability later in life. In a similar vein, one study reported a relationship between symptoms of Posttraumatic Stress Disorder and hypnotizability. Such findings appear to be particularly interesting, as rates of childhood physical abuse amongst men who sexually abuse are relatively high. Therefore, such results appear to confirm, along with research

that reports higher hypnotizability amongst adult sex offenders, that hypnotic techniques might be efficacious in this population.

There are few studies that address the issue of association between childhood trauma and consequent adult dissociation in the sex offender population. Unfortunately, one of these studies (Ellason and Ross, 1999) lacked proper statistical analysis. The other study (Graham, 1996), however, strongly suggested a link between the severity of childhood abuse and the level of dissociation. Such a link was also found in the general population.

In general, the psychological literature acknowledges that the rates of physical and sexual abuse among persons who sexually offend are significantly higher than those in the general population. This statement appears to be true for both genders with women suffering even more childhood abuse than men with respect to frequency and severity. In addition, some studies claim that the incidence of childhood abuse in the sex offending population is higher than that in other groups of offenders, while other research fails to show such differences.

Rates of childhood abuse among persons who sexually offend vary greatly depending on the type of research, definitions and methodology employed. Variations in such rates cause heated debates in the etiology of sex offending as the role of childhood sexual abuse amongst persons who sexually offend is strongly emphasized in some theories of sexual offending. Precise rates of the incidence of childhood abuse amongst sex offenders are not of interest here. The main conclusion that arises from this chapter is that a certain percentage of sex offenders have experienced various types of childhood

trauma that can lead in some of these offenders to the development of pathological dissociation in adulthood. In addition, it is possible that perhaps different types of trauma (e.g., physical abuse) are more significant in the development of subsequent dissociation in this population than in the general population. However, it seems plausible that in general, the etiology of adult dissociation in both groups is similar. The main difference lies in the fact that most research in the normal population group has been conducted on female subjects while the population of sex offenders consists mostly of males. There is therefore a need for more research that directly explores childhood trauma experiences in sex offenders and subsequent pathological dissociation.

Childhood trauma of various types appears to be the chief pathway leading to pathological dissociation in adolescent and adult male and female sex offenders. There might also be other means of development of dissociative pathology in sex offenders. Some researchers postulate that adult trauma, for example, might be a source of dissociative pathology. In addition, the use of drugs appears to coincide with experiencing altered states of consciousness in sex offenders who commonly report the use of alcohol at the time of the offense.

A hypothesis for *how* dissociative mechanisms may accompany sexually offensive acts is analyzed in detail in the following chapter. Implications for therapy for sex offenders with regard to dissociative pathology are also discussed.

CHAPTER IV

DISSOCIATIVE PATHOLOGY AND SEX OFFENDING: A MICROANALYTIC APPROACH

A model that attempts to explain the presence of pathological dissociation in sexual offending will be proposed in this chapter. Such a model will address the following aspects of dissociation in sexual offending: triggers of dissociative states, dissociation in different stages of the offense process, the relation between cognitive distortions and dissociative states, and consequences of dissociation in sex offending. Moreover, a proposed model of pathological dissociation in sex offending behavior will be contrasted and compared with the concept of cognitive deconstruction proposed initially by Baumeister (1990) and later developed in relation to sex offending by Ward and Hudson (1998). The model of dissociation in sexual offending proposed here is of a theoretical nature. However, empirical and clinical research could be employed in order to test the validity and clinical utility of such a model.

It is not the aim of this chapter to propose dissociative pathology as yet another factor in the etiology of sex offending. Sex offending behavior appears to be a particularly complex type of criminal behavior whose etiology has been proposed in the form of integrated theories (e.g. Marshall and Barbaree, 1990).

The presence of dissociative pathology, like the presence of any other pathology, such as depression or anxiety, does affect patients' behavior. Whether such behavior is criminal or not depends on the patient's history, though the alteration of that behavior by dissociation can be significant and cause serious consequences for the person. The impact of dissociative pathology on the behavior of some sex offenders and the consequences of such an impact will be discussed in this chapter.

TRIGGERS, DURATION AND CONSEQUENCES OF DISSOCIATION IN SEXUAL OFFENDING: MODEL OF DISSOCIATIVE PATHOLOGY IN THE SEXUAL OFFENSE PROCESS

There are several issues that arise with respect to the model of dissociative pathology in sex offending behavior. Firstly, the model should attempt to explain the mechanisms that trigger dissociative states in sex offenders who suffer from dissociative pathology. Secondly, it is necessary for an efficient model to propose the stages of the sexual offence process that are accompanied by dissociative states. Thirdly, the model should attempt to explain some of the phenomena characteristic of sexual offending (e.g. cognitive distortions) as well as the consequences of dissociative states in sex offending

(e.g. amnesia). Finally, the model should also propose clinical implications for a potential treatment that would address pathological dissociation and its consequences in sex offenders.

TRIGGERS OF DISSOCIATIVE STATES IN SEX OFFENDERS

It seems that the most typical mechanism that activates dissociative states in persons who sexually offend can be related to state-dependent learning. Braun (1988, p.5) describes this phenomenon as follows: "something that is learned in one neuropsychophysiologic state is most expeditiously retrieved under the same neuropsychophysiologic state." Therefore, sex offenders who were abused as children themselves and have consequently developed a dissociative defense, might experience a dissociative state when exposed to the cues associated with their previous abuse. The literature generally supports the concept that trauma-associated cues can trigger a variety of dissociative states, including those PTSD-related such as flashbacks. Braun (1988), for example, presents case studies of his dissociative patients who re-lived their childhood abuse events due to various cues associated with their abuse, such as a loud noise (reminding the patient of the gun's firing); being hit with a cane (reminding the patient of her mother hitting her with a cane), and others. Distressing recollections of the traumatic event are widely recognized as dissociative symptoms (Horowitz, 1986; DSM-IV, 1994) which can be brought about through mechanisms described by the concept of fear structure (Foa and Kozak, 1991). Such a concept postulates that the fear network is activated by stimuli similar to those present at the time of trauma. Steinberg and Schnall (2000, p. 15) gives an example of such an instance:

> For people whose trauma response system is out of control, the past becomes indistinguishable from the present. Any reminder of the trauma can set off a Pavlovian reflex, as it does in the shell-shocked combat veteran who hears an automobile backfiring in the street and runs into the closet to hide. Over time any stressor, even one not remotely reminiscent of the trauma or abuse, can trigger a similar response.

It is possible also that dissociative states other than those that are PTSD-related (e.g. distressing recollections) can be triggered by abuse-associated cues. In Sybil such cues (broken glass and the smell) were described as triggers of the process of switching to a different identity (Schreiber, 1973, p.23):

> The crash of glass made her head throb. The room swirled. Her nostrils were suffused with the acrid smell of chemicals, more than an inhalation of what was actually there. The smell seemed to emerge from some far-off memory of an experience long forgotten. That smell, so distant and yet so familiar, was reminiscent of the old drugstore at home. The broken glass in the old drugstore. The broken glass in the big dining room. Both times there had been the accusing voice: "You broke it."

This quotation from Sybil appears to suggest that dissociative states, in some instances, can be brought about mostly by external triggers and without the control of the patient. It appears plausible that this particular mechanism might also take place in some sex offenders who experienced repetitive childhood abuse and have elevated dissociative

scores as adults. Such persons may have learned, as children, to escape cruel reality by stepping into their dissociative world. As a consequence, such an escape can take place in their adult lives every time that a signal of danger or abuse is present. Maynes and Feinauer (1994, p.171) broaden the concept of mechanisms activating dissociative states beyond those related to past abuse and postulate that

> an individual who has been abused, who also has the ability and tendency to dissociate, would use this coping skill on a day-to-day basis to manage stress and anxiety more often than an individual who has not needed to use the mechanism to cope with trauma.

Therefore, it appears that once people have learned how to dissociate they can utilize these skills in all sorts of everyday stressful situations. By analogy, one may assume that a stressful situation may trigger a dissociative state in some sex offenders.

DISSOCIATION IN STAGES OF THE SEXUAL OFFENDING PROCESS

Ward and Hudson (1998) propose a *life event* as a first step in their self-regulatory model of the relapse process in sexual offenders. This model consists of 9 different phases: 1) Life event; 2) Desire for deviant sex or activity; 3) Offence-related goals established; 4) Strategy selected; 5) High-risk situation entered; 6) Lapse;
7) Sexual offence; 8) Post-offence evaluation; and 9) Attitude towards future offending. According to Ward and Hudson (1998), the first phase in the offending cycle may be described as "a major life transition, for example, a divorce, or a daily hassle, such as an argument" (Ward and Hudson, 1998, p. 798).

Thus, it is possible that such sexual offenders enter another stage of the offending cycle, *desire for deviant sex or activity,* already in a dissociated state of consciousness. Ward and Hudson (1998, p.708) believe that in this stage

> [s]exual and aggressive fantasies frequently coexist with these desires (for offensive sex or maladaptive activities and emotions associated with these desires) and could function as mental simulations, increasing the possibility of abusive behavior occurring.

A fantasy element strongly present in this phase appears to suggest that a dissociative state may be present there. In fact, Ross (1996) lists *absorption-imaginative involvement* as one of the three main factors involved in dissociation. However, the relationship between aberrant sexual fantasies and dissociative states in men who sexually offend will be discussed later.

In general, this thesis assumes that some sex offenders may slip into a dissociative state in the very first step of the offensive cycle. This may happen due to the presence of the cue(s) associated with their past abuse or some other stressful situation. Consequently, this thesis argues that such offenders may remain in an altered state of consciousness throughout the next stages of the offense cycle.

These remaining stages that Ward and Hudson (1998) proposed will be simplified to two only for the purpose of this paper. A possible presence of dissociation in a post-offence phase will be discussed here, while dissociative processes during actual

offending will be addressed throughout later in the chapter. However, it is worth noting at this point Graham's (1993, p.51) view on the role of the dissociative defense in general and specifically during a sexual offense:

> It serves to remove the individual from life events perceived to be stressful, and more importantly in the case of sexual offenders can remove them from the trauma being caused to the victim in the commission of the assault.

Generally, three distinct groups of sexual offenders, with regard to the type of post-offense evaluation, are proposed in Ward and Hudson's (1998) model of the offense process. The first group comprises offenders who, according to the model, should evaluate themselves negatively and feel guilt. Ward and Hudson (1998, p.717) describe two other possible groups:

> Men who continue to cognitively deconstruct, or function at relatively basic levels of behavior control, may not evaluate their actions until some later time. Offenders who have approach goals should experience positive affect due to they [sic] have achieved their goals.

Briefly, it appears that with regard to the aftermath of a sexual offense, some sexual offenders experience negative affect, others positive affect, and some simply suspend evaluation of their offensive behavior. One can only hypothesize as to which groups of offenders would be likely to dissociate after the offense. Offenders who suspend the evaluation of their offending behavior, for example, may be affected by continuing dissociative processes. Those with post-offense negative affect appear to be "out" of a

dissociative trance (assuming that they experienced dissociation while offending) as they are usually flooded with strong feelings of guilt, shame, and wrongdoing.

Pryor (1996, p.165) comments on how offenders feel after sexual contact with a victim:

> Most of the men had a sense that they probably should not be doing what they were doing. For the most part, however, moral feelings did not strongly enter into the picture until the act itself was actually in progress, but typically within the first few minutes after its completion.

It is possible that some of the men who experience positive post-offense affect may have dissociated during this phase. It appears that the dissociative processes can defend them from the reality of broken social and moral norms and allow them to maintain cognitive distortions. This is a tentative hypothesis only that requires empirical testing as such a type of post-offense behavior may be due to other than dissociative processes. Pryor (1996), for example, believes that men who reported an absence of guilt had themselves been extensively involved in childhood sex with someone older and had normalized their experience.

COGNITIVE DISTORTIONS AND DISSOCIATION

It seems that some of the mechanisms that mediate the expression of non-pathological dissociation may also play a role in pathological dissociative states in some sexual offenders. Therefore, the relationship between the presence of deviant fantasies and cognitive distortions, and the presence of dissociation in sexual offending, will be discussed subsequently to the concept of sources of non-pathological dissociation.

Ludwig (1983) discusses functions of non-pathological dissociation and proposes that dissociative reactions and their many forms and guises serve important functions for people and possess great survival value. He lists 7 functions of dissociative reactions. One such function, *resolution of irreconcilable conflicts,* appears to contribute particularly to our understanding of mechanisms that may trigger dissociative states in persons who sexually offend. According to Ludwig (1983) and Steinberg (1995), dissociative states seem ideally suited for dealing with basic conflicts with no immediate means of resolution because:

> By automatically relegating one set of attitudes, wishes and values to one state of consciousness and a conflicting set to another, the individual at least has some basis for concerted action. Opposing drives or desires can be expressed in a sequential, but not integrated, way (Ludwig, 1983, p. 96).

Ludwig (1983) also proposes "trance logic" as yet another way of dealing with conflicting information. He argues that critical judgment is suspended so that opposites can be equal and contradictions cease to exist in such a trance. Moreover, another advantage of this capacity is that it allows the individual to abnegate responsibility for attitudes and wishes not acceptable during ordinary, waking consciousness .

It appears that this particular function of dissociation, that facilitates the resolution of irreconcilable conflicts, can be related to the presence of distorted thinking in some sex offenders. According to Murphy (1990, p. 103), cognitive distortions are: "self statements made by abusers which allow them to deny, minimize, justify, or rationalize their behaviour." One form of distorted thinking in persons who sexually offend is

denial, a multi-faceted phenomenon that reflects a desire on the part of the perpetrator to avoid acknowledgment of the details and ramifications of offending behavior. Denial is manifested in various ways: denial of abuse having occurred; denial of having "perpetrated abuse;" denial of full or part responsibility for the commission of abusive acts; denial of harm to the victim during abuse; denial of the likelihood of further abuse occurring; and denial of the impact of abuse on significant others (Briggs, Doyle, Gooch and Kennington, 1998). The first type of denial, when a sex offender disclaims his/her offense as a possible consequence of the amnesia for the offense due to the dissociative state, will be discussed later in this chapter.

It is possible that the irreconcilable conflict discussed by Ludwig (1983) is present in sex offenders in the form of internal inhibitions against acting on motivation to abuse. In fact, Finkelhor (1984) postulates that overcoming any such internal inhibitions is one of four necessary preconditions that must be met before sexual abuse can occur. However, he does not explain in detail the process of "overcoming" and states: "commonly this is by way of 'cognitive distortions'..." (Finkelhor, 1984, p.54). This thesis postulates that some sex offenders may overcome such internal inhibitions by the use of dissociation.

It seems plausible that dissociative states with the content of deviant sexual fantasies may facilitate neutralizing internal inhibitions. Maletzky and Govern (1991) state that some sexual abusers develop long-term aberrant arousal patterns due to aberrant sexual fantasies and deviant masturbatory behaviors cultivated for years. Therefore, it can be postulated that deviant fantasies and aberrant sexual arousal are experienced and repeatedly "practised" during dissociative states in some sex offenders. Such repetitive

practices may in turn lead to overcoming internal inhibitions and as a result, possibly, to adopting cognitive distortions. In addition, it also seems plausible that repetitive, "dissociative rehearsals" with the deviant content may make sex offenders particularly sensitive to cues present in their dissociative sexual fantasies. The state-depending learning processes appear to play an important role here. Therefore, one can theorize that sex offenders can "slip" into a dissociative state if they find themselves in a high-risk situation that reminds them of the scenario rehearsed previously in a dissociative trance. Ward and Hudson (1998) describe this stage as characterized by contact or opportunity for contact with the potential victim.

A clinical example of the mechanism described above was illustrated by Diamond (1969). He described the case of the assassin of Robert Kennedy, Sirhan B. Sirhan, who mastered self-hypnosis and was able to throw himself into trances. According to Diamond (1969), Sirhan experienced a typical dissociative symptom such as amnesia in that he did not remember that he had killed Kennedy, though he did not deny it. In addition, he was an excellent hypnotic subject. It seems that Sirhan had some control over the induction of dissociative states during the early stages of mastering auto-hypnosis. During such dissociative trances, induced with the aid of candles lit in front of a mirror, he "programmed himself" for the assassination of Robert Kennedy. However, it appears that the tragic incident, the actual assassination of Kennedy, happened during a trance that was uncontrollably triggered by the cues that served previously to elicit dissociative trances: mirrors and dazzling lights. Diamond (1969, p.55) explains it as follows:

> he [Sirhan] finds himself in this alcove with dazzling lights and mirrors. He feels bewildered and dazed. ... I'm satisfied that the lights and mirrors triggered off the same kind of dissociated state that he had practiced in the Rosicrucian exercises.

AMNESIA FOR THE OFFENSE AND DENIAL OF THE OFFENSE IN SEX OFFENDERS AS A CONSEQUENCE OF DISSOCIATIVE STATES

This thesis proposes that offenders with elevated dissociative scores may experience amnesia for the offense as a potential consequence of a dissociative state occurring during the offense. The presence of amnesia in persons who sexually offend was previously discussed in Chapter II. However, there are several caveats with regard to the presence of post-dissociative amnesia consequent to a dissociative state in sexual offenders. First, the prevalence of amnesia in sex offenders varies depending on the study. Second, it seems that denial of the offense, in addition to classical amnesia for the offense, may be considered as yet another potential consequence of dissociative states in sexual offenders. Third, the relationship between amnesia and alcohol appears to be complex and requires further empirical exploration. Fourth, it appears to be extremely difficult to differentiate true amnesia from "faked" or "malingered" amnesia (Schacter, 1986).

These problems should be addressed by future research. This thesis proposes on the basis of currently available empirical and clinical evidence that amnesia for the offense in men who sexually offend, and possibly some cases of the denial of the offense may be a result of a dissociative state occurring during the offense. The presence of such phenomena may seriously impede the rehabilitative process by "blocking awareness" of

the facts of sexual offending. The research appears to confirm a hindering impact of this denial on the treatment of sex offenders. Maletzky and McGovern (1991, p.254), for example, state:

> The manner in which the patient regarded his offender behavior also bore some relevance to the issue of failing treatment. For example, an offender who wholly denied allegations of sexual abuse was three times as likely to fail than [sic] the offender who even partially admitted his complicity.

Consequently, many rehabilitative centers perceive the presence of broadly defined denial in sex offenders as an exclusion criterion from their programs. The Twin River Sex Offender Treatment Program's (Gordon and Hover, 1998, p.5) main eligibility criteria, for example, are: " The offender must aknowledge that he has committed a sexual offense, must not be mentally ill, and must volunteer." Other treatment programs appear to have slightly less strict eligibility criteria with regard to denial. The treatment program for child offenders in New Zealand, Kia Marama, for example, does not exclude men who have not admitted, at least initially, the offenses for which they were convicted (Hudson, Wales and Ward, 1998). However, "persistent total denial ... result[s] in the man being discharged from the program" (Hudson, Wales, and Ward, 1998, p.18).

One has to bear in mind that denial is a multifaceted concept, and the denial of the offense is only a single facet of such a concept. In addition, amnesia for the offense may often be of organic rather than psychogenic (e.g. dissociative) origin (O'Connell, 1960). Therefore, it seems necessary to exclude other than psychogenic causes of amnesia in

offenders who claim amnesia for their offense. In addition, further confirmation of a dissociative source of amnesia for the offense may be obtained by taking a history of dissociative pathology in men who sexually offend. Amnesia is only one of many dissociative symptoms that can suggest that some offenders experience dissociation during the offense. The presence of symptoms of dissociation other than the amnesia for the offense such as depersonalization, derealization, identity confusion, or identity alteration may be assessed through clinical interviews (Steinberg, 1995).

COGNITIVE DECONSTRUCTION AND DISSOCIATION IN SEXUAL OFFENDING: COMPARATIVE APPROACH

Ward and Hudson (1995) proposed a cognitive deconstructionist interpretation of cognitive distortions and affective deficits in sex offenders in order to explain the processes that may lead to these distortions and affective deficits. According to the authors, the psychological theory neither explains the origins adequately nor identifies the mechanisms through which such distorted thinking and feeling arises. Moreover, it seems that Ward and Hudson (1995) were also inspired by the research findings suggesting that deficits in emotional expression in sexual offenders, particularly lack of empathy and suppression of negative emotions during the offense process, may be specific to the process of offending rather than general in nature. Ward and Hudson's (1995, p. 70) stand on this issue is illustrated by the following statement:

> Consistent with this view is the report by many sex offenders that, once they engage their offence chain, it is as if all their usual judgmental processes and

> self–directions are suspended. Many offenders note that after their first offence, in particular, they could not understand why they had committed an act which they had previously thought to be extremely offensive.

The construct of cognitive deconstruction in sexual offending also attempts to account for the presence of distorted rationalizations that initially facilitate offending and, once offending has occurred, serve to avoid any sense of guilt. The model proposed by Ward and Hudson (1995) has its significance in clarifying further an etiologic and offense-maintaining role of distortions and deficits in sex offenders. In addition, this model suggests implications for the assessment and treatment of this population. It appears that there are several similarities between the model of dissociation in sexual offending and the cognitive deconstructionist interpretation of cognitive distortions and affective deficits in sex offenders. Therefore, a comparison of both models may lead to a better understanding of the offense cycle in men who sexually offend.

COGNITIVE DECONSTRUCTION: GENERAL CONCEPT

This section will briefly describe the concept of cognitive deconstruction in general terms. It may appear that there is some resemblance between the concept of dissociation and that of cognitive deconstruction. However, there are many dissimilarities too. It is not my intention to compare the concepts of cognitive deconstruction and dissociation. Such a comparison is beyond the scope of this thesis and it does not seem to contribute to the development of the model explaining symptoms and phenomena related to the offense process. However, in order to test the validity of the newly proposed model of

dissociation in sexual offending, this model will be contrasted and compared with the concept of cognitive deconstruction in sexual offending.

Originally, the concept of cognitive deconstruction was developed by Baumeister (1990) who defined cognitive deconstruction as the attempted refusal of meaningful thought, particularly with reference to integrative, interpretive mental acts. According to Baumeister (1990), the person limits the degree of cognitive elaboration that he or she performs, instead of controlling the focus of attention. Moreover, cognitive deconstruction requires abandoning the normal mode of understanding the world (involving interpretations, analyses, and evaluations) and encountering it as a set of stimuli, simple associations, and immediate responses. In addition, all this occurs "as an attempt to escape from troubling thoughts or implications" (Baumeister, 1990, p. 276).

The main idea of Baumeister's (1990) model is that there are multiple, hierarchically structured levels of meaning associated with human action. Such levels of meaning vary from highly abstract to concrete levels of meaning or interpretation where each level has specific goals and strategies associated with it. Baumeister (1990) argues that particular levels appear to be activated by the means of attention. Therefore, escaping from self-awareness would involve narrowing the focus of attention from abstract or higher levels to concrete or lower levels. It seems that negative affect and perception of emotional threats, as well as perceived failure, may produce a shift toward low levels of awareness (Ward and Hudson, 1995). Generally, the main characteristics of the deconstructed state are: 1) cognitive immediacy characterized by a narrow focus of awareness on the immediate present; 2) procedure orientation (means are more proximal than ends);

3) passivity and impulsivity; 4) close-mindedness; 5) proneness to inconsistency and contradiction; 6) disinhibition; 7) removal of emotions; 8) cognitive vulnerability to irrational thinking, fantasy, and external influence (Baumeister, 1990).

COGNITIVE DECONSTRUCTION IN SEX OFFENDERS

Ward and Hudson (1995) propose that the vulnerability that may arise due to poor developmental experiences, or from current stresses in the offender's life, or from both, is a key factor in triggering the offense, or an offense pattern. The presence of such vulnerability may lead to feelings of inadequacy in potential offenders. This in turn generates negative emotional states that can elicit a cognitively deconstructed state in a person. Such a state may induce a strong need for gratification which, if combined with an opportunity to offend sexually, may result in the sex offense. Ward and Hudson (1995) believe that different offenders may display different patterns of cognitive deconstruction. With regard to developmental issues and cognitive deconstruction, these authors assume that a vulnerable adolescent in a constant state of stress easily adopts a cognitive deconstructive style.

Consequently, Ward and Hudson (1995) propose two types of sex offender. The first type comprises those who begin their offending early in life and display a cognitively deconstructive style as a general behavioral style. Such offenders, according to the authors, are less likely to show any signs of guilt, embarrassment or remorse and are likely to admit having offended. The second type consists of sex offenders whose first offense is in adulthood. According to Ward and Hudson (1995) such men should display cognitive deconstruction only with respect to their offenses, and as a result they

should experience guilt, and be more likely to deny or minimize their offenses. Ward and Hudson (1995, p.76) explain as follows why the denial is present in this group: "Once they have offended, these men must sustain a cognitively deconstructed level of processing, if they are to avoid the aversiveness of a negatively evaluated self-image."

It appears that both models, those of dissociation and cognitive deconstruction in sexual offending, point towards similar origins of dissociation and cognitively deconstructed style in men who sexually offend. The former conceives childhood trauma to be the chief pathway in the etiology of dissociation, while the latter blames adverse developmental experiences for sex offenders adopting a cognitively deconstructed style. It also appears that both models recognize that stressful situations are potential triggers of either dissociative states or cognitively deconstructed states, with regard to the offending process.

Ward and Hudson's (1995) classification of sex offenders with regard to when they begin to offend and their cognitively deconstructive style seems to be extremely valuable but quite separate from the concept of dissociation in men who sexually offend. It is after all possible that the distribution of dissociative experiences in such groups is similar to that of cognitively deconstructive states. Empirical studies are required to test the hypothesis that dissociative levels and their intensity, and the type of their consequences, may differ in groups of offenders with regard to the age when they start offending. In fact, such research would enable the proposal of a more detailed model of dissociation in sexual offending (e.g. identification of various groups of dissociative sex offenders, the presence or lack of amnesia or denial in such groups).

However, there is also some similarity between both models with respect to the presence of a deconstructed state and a dissociative state in the post-offense stage of the offense process. The model proposed in this thesis theorizes about the possibility of maintaining a dissociative state after the offense has happened, based on Ward and Hudson's (1998) model of the offense process. I assume that sex offenders who would experience positive affect after the offense or suspend their judgment may still be in a dissociative state. Ward and Hudson's (1995) cognitive deconstructionist approach proposes that offenders who begin to offend later in life may sustain a deconstructed state once they have offended. The similarity here appears to be obvious in that there might be a group of sex offenders who still dissociate or remain in a deconstructed state after the offence has happened.

A distinction has been suggested between " cognitive distortions that accompany, or are associated directly with, a cognitively deconstructed state and those that occur as a consequence of such a state" (Ward and Hudson, 1995, p.76). The failure to be aware, during the offense, of the long-term negative consequences for a victim is an example of the cognitive distortion that occurs during the offense. An example of the cognitive distortion that occurs as a consequence of a cognitively deconstructed state may be "blaming a victim for inappropriate sexual contact" (Ward and Hudson, 1995, p. 77). The model of dissociation in sexual offending can also account for the presence of both types of cognitive distortions. This model proposes that cognitive distortions that occur within dissociative states during the offense process may have been "rehearsed" before in dissociative deviant fantasies. However, cognitive distortions that are a consequence of the offense are quite distinct from those that occur during the offense. They may, for

example, take the form of denial of the offense due to dissociative amnesia. It was also postulated earlier that post-offense dissociative distortions, unlike other distortions, "protect" the offender from realizing the consequences of the offense. Such distortions may often result in either positive affect or delay in the evaluation of the offense behavior.

Covert planning (passive planning) in sex offenders may also be explained by the cognitive deconstruction analysis. According to Hudson, Ward and McCormack (1999), such planning is characterized by the adjustment of circumstances by the offender in order to facilitate contact with a potential victim (setting up a high-risk situation), and the lack of acknowledgment of this planning. The model of dissociation in sexual offending proposed in this thesis can also account for these features. The lack of acknowledgement of the covert planning may be explained, for example, by amnesia, assuming that the covert planning was accompanied by a dissociative state.

Finally, Ward and Hudson's (1995) analysis attempts to explain sex offenders' lack of empathy for the victim as a result of a cognitively deconstructed state occurring during the offense. Ward and Hudson (1995) theorize that such a deficit is expected to be restricted to the offender's victim(s) rather than a commonly seen broadly based personality defect. The model proposed in this thesis also appears to account for such a phenomenon, in particular when dissociation is conceptualized according to a BASK model. The BASK model (the four letters of the acronym represent **B**ehavior, **A**ffect, **S**ensation, and **K**nowledge - processes that function in parallel on a time continuum) conceives that dissociation can occur in one or more of these processes (Braun, 1988).

Therefore, one can theorize that specific lack of empathy for the victim may be due to a possible dissociation between the level of Affect and other levels proposed in the BASK model. Practically, it can mean that due to such a disconnection, the act of the offense was not associated and integrated with the feeling of empathy. As a result, the offender "cannot" experience and express empathy for his/her victim once the offence has happened. In a similar vein, Steinberg and Schnall (2000, p.53) includes a "sense of detachment from your emotions" as one of many characteristics of depersonalization.

Generally, it seems that both models, the model of dissociation and the model of cognitive deconstruction, can account for features of sexual offending such as cognitive distortions and affective deficits. There are differences and similarities between these two accounts. It appears, for example, that the phenomenon of amnesia for the offense in sex offenders may be better explained by the dissociative model. Both theories acknowledge the role of adverse environmental factors in the development of either the cognitive deconstructionist style or pathological dissociation in some sex offenders. However, the model of dissociation in sexual offending appears to emphasize the role of childhood trauma as the chief etiologic factor of pathological dissociation. Additionally, the cognitive deconstructionist model appears to assume the etiologic role of cognitive distortions and affective deficits in sex offending. In contrast, the dissociative model attempts only to specify the presence of dissociative pathology in particular stages of the offense chain and the consequences of dissociative processes.

Finally, it appears that useful clinical implications for treatment can be drawn from both models. However, it seems that the cognitive deconstructionist analysis proposes

implications for therapy that are to be rather general in nature (Ward and Hudson, 1995, p.79):

> Therapy essentially aims at raising cognitive processing to a more abstract level at which the offender must face the real damage he has done. ... The main treatment implication of this approach is that the therapist must help offenders to recognize the nature and disadvantages of their deconstructive style and the benefits of dealing with issues at a more abstract level.

In addition, it appears that at present there is a lack of psychometric instruments that would help identify a cognitive deconstructionist style in patients. Such identification can be achieved by the means of clinical interview, though the validity and reliability of such assessment may be compromised. This is in contrast to the assessment of dissociation which offers several valid and reliable psychometric tools.

Moreover, the dissociative model provides clear and detailed clinical implications with respect to therapy for sex offenders. First, by addressing childhood trauma in sex offenders one may attempt to reduce dissociative pathology. This in turn, it is hoped, would facilitate therapy with sex offenders by breaking their amnesic barriers and reducing denial.

Second, it is proposed that hypnotherapy can be potentially an efficacious tool in therapy with sex offenders because of their increased hypnotic and dissociative abilities. Hypnosis in programs for sex offenders may be utilized, for example, to reduce amnesic barriers in persons in denial of their offense. It seems that a hypnotic element could be incorporated into various stages of current cognitive-behavioral programs for sexual offenders. The clinical implications of the dissociative model in sexual offending will be discussed in the following chapter.

CHAPTER V

CLINICAL IMPLICATIONS FOR TREATMENT OF SEX OFFENDERS

The previous chapters have indicated, based on the literature, the significant presence of dissociative pathology in sex offenders. Moreover, the psychological literature appears to suggest strongly that childhood trauma is the chief factor in the etiology of pathological dissociation in the non-sex offender population. By analogy, this thesis argues that childhood abuse is also the main pathway in the development of dissociative pathology in some men who sexually abuse. Consequently, this thesis proposes that childhood trauma, if reported, must be addressed in the treatment of persons who sexually offend. Inclusion of childhood abuse issues in therapy for this population appears to be necessary in order to alleviate pathological dissociation and other types of psychopathology that are present amongst sex offenders.

The model proposed in this thesis strongly argues that pathological dissociation may be present in the main stages of the sexual offending process in sex offenders with elevated dissociative scores. It has also been argued that the presence of dissociation in sex offending can result in serious consequences such as amnesia for the offense and

possibly denial of the offense. In addition, it seems that dissociative abilities may be, partially at least, "responsible" for the maintenance of cognitive distortions and deviant fantasies in sex offenders who suffer from dissociative pathology. Thus, this chapter will briefly argue the reasons for addressing dissociative pathology and its source, such as childhood abuse, in treatment programs for sex offenders. Possible therapeutic gains as a result of such an approach will also be discussed here.

The assumption that dissociative experiences lie on a continuum has been accepted by many researchers of dissociation. In simple terms, one may say that such a model perceives pathological dissociation (e.g. dissociative disorders) and hypnosis as two forms of the same phenomenon called *dissociation.* Spiegel (1994, p.186) claims that: "Hypnosis can be understood as controlled and structured dissociation, a normal microdissociative episode." Hypnosis and various forms of dissociation also differ in many characteristics. The major difference between them relates to the field of psychology to which they belong. Hypnosis is *an adjunct to therapy,* while dissociative disorders or other more severe forms of dissociation belong to *psychopathology.* However, according to the continuum model, there seems to be a "common denominator" in the form of dissociative phenomena for both pathological dissociation and hypnosis. Maldonado, Butler and Spiegel (1998) summarize this concept with respect to recovery of traumatic memories:

> Most patients suffering from dissociative disorders are highly hypnotizable. ... If hypnotic-like states are used during traumatic experiences, it makes sense that the very entry into this same state could lead to the retrieval of

memories and affects associated with original trauma, as would be predicted by the theory of state-dependent memory.

In brief, it seems that some forms of hypnotherapy may be effective for persons who suffer from dissociative pathology, effective because of these patients' high hypnotizability. On the other hand, some research questions close links between dissociative phenomena and hypnosis (Whalen and Nash, 1996). Even if one accepts this view, the research confirming links between severity of childhood abuse and hypnotic abilities would justify the hypothetical usefulness of hypnosis in the treatment of sex offenders. The literature clearly shows that the rates of childhood physical, sexual, and emotional abuse are significantly higher in this group than in the general population. As a result, one would expect relatively high hypnotizability in sex offenders with a history of childhood abuse.

Consequently, this thesis postulates that hypnosis and its characteristics, such as increased suggestibility, or memory enhancement, may be an efficacious assessment and therapeutic technique for sex offenders with elevated dissociated levels. In addition, it seems that particular hypnotic techniques such as the "as if" technique or "age progression" technique can be potentially appropriate in the "relapse prevention" stage of current cognitive-behavioral therapies. These techniques will be discussed in detail later.

In summary, this chapter will briefly critically review currently available research results regarding the use of hypnosis in therapy for sex offenders. In addition, I will argue for the inclusion of a hypnotic element in contemporary cognitive-behavioral

treatment programs for sex offenders with elevated dissociative scores. The potential utilization of hypnosis-based techniques in therapy for men who sexually abuse will be discussed with regard to particular components of current rehabilitative programs that may profit from the addition of hypnosis.

REDUCING DISSOCIATIVE PATHOLOGY IN SEX OFFENDERS

CHILDHOOD TRAUMA

According to the research findings quoted in the previous chapters, childhood trauma is the main etiological factor in the rise of pathological dissociation. Additionally, many other forms of psychopathology have their origins in childhood abuse experiences. Therefore, intuitively it appears that childhood victimization should always be addressed in the therapy of sex offenders who experienced such victimization. Resistance amongst some clinicians towards such an approach seem to be based on the lack of controlled research regarding the efficacy of this approach and a moral-related dilemma. This dilemma is concerned with the possibility of sex offenders justifying their offending by their own childhood abuse. However, Briggs and Hawkins (1996, p.221) dismiss this concern with the following statement: "Our offenders did not use their own abuse as an excuse."

It appears that childhood abuse experiences in the population of sex offenders need to be dealt with early in the assessment stage. The exploration of a history of childhood trauma would be necessary in order to assess how pathological dissociation arose. Consequently, abreactive work (intensive reliving of a traumatic experience) or other

original trauma-focused therapeutic techniques may be required to reduce a patient's distress caused by PTSD symptoms or other dissociative symptoms. Techniques of abreaction are aimed at restoring memories of the original trauma, reconnecting the feelings associated with the trauma, and revising the cognitive distortions such a trauma produced (Schwartz, Galperin and Masters, 1995).

In general, the issue of therapy for persons who experienced childhood abuse, including sex offenders abused as children, is beyond the scope of this thesis. To date research appears to be unclear as to what kinds of treatment are effective with survivors of abuse. For example, almost all of the literature on individual treatment is based on clinical reports (Holmes, 1995). In general, approaches to therapy for persons who were abused as children appear to be doctrine rather than theory driven.

These approaches vary from the cognitive-behavioral, maintaining that clinical manifestations of childhood trauma-related psychopathology should be the primary focus of treatment and research, to the more psychodynamic. The latter often claim that symptoms of themselves are of little value for planning specific and differentially effective treatment programs and that treatments based on unique etiological histories may yet prove to be superior. The author of this thesis strongly supports such a view and proposes that the original trauma must be addressed in therapy for dissociative sex offenders. The following statement based on Graham's (1996, p. 201) clinical practice describes the potential benefits of addressing childhood trauma in sex offenders:

> It has been our experience that as the offender is helped to get in touch with his own dissociated feelings concerning his own abuse, his capacity for

> empathy towards others is greatly increased. He also comes to feel less alienated and grows in his potential for healthy intimacy with others.

SPECIFIC THERAPEUTIC TECHNIQUES FOR REDUCING DISSOCIATIVE PATHIOLOGY

Similarly to the treatment of survivors of sexual abuse, the effectiveness of psychological treatment for any dissociative disorder has not yet been evaluated by means of controlled studies (Maldonado, Butler and Spiegel, 1998). Most of the literature addresses the treatment of Dissociative Identity Disorder (DID), though it seems that our current knowledge of the diagnosis and treatment of DID is based almost entirely on pragmatic clinical experience (Putnam, 1986). However, the findings from a few studies that were conducted on DID appear to send a strong warning about psychological treatment neglecting symptoms of DID:

> patients suffering from DID do not experience spontaneous remission of their illness if left untreated. Likewise, reports have suggested that the treatment of the many symptoms and associated diagnoses do not help in the resolution of the problem unless the dissociation is addressed directly (Maldonado et al. 1998, p. 432).

It is difficult to argue without employing controlled studies that, by analogy, forms of dissociative pathology other than DID always need to be addressed separately in therapy and that these are time-resistant. However, the above quotation appears to signal that the presence of pathological dissociation cannot be dismissed in any clinical population. The elevated dissociative scores in the sex offender population indicated by the

literature should make clinicians particularly sensitive with regard to the assessment and treatment of dissociative pathology.

A broad array of therapeutic techniques is employed in order to alleviate or eliminate dissociative pathology in the clinical population. Such techniques also appear to vary with respect to the type of dissociative disorder. Hypnosis appears to be a useful treatment tool that is utilized widely in the treatment of dissociative pathology, and the utilization of hypnosis in the therapy of men who sexually offend will be addressed later. This section critically reviews therapeutic techniques that aim to reduce dissociative pathology, excluding DID, with respect to the sex offender population. Subsequently, cost- and time-effective techniques for the alleviation of pathological dissociation in men who sexually offend will be suggested.

Ego state therapy

Ego state therapy is a technique that deals with original trauma-focused issues by utilizing hypnosis. However, hypnosis is not a necessary component of this treatment as a non-hypnotic version of ego state therapy has been developed recently (Watkins and Watkins, 1995). Ego state therapy aims at the reduction of patients' dissociative levels through an integration of frozen in time and split-off parts of the self that are trauma-based. This therapy is generally recommended as potentially effective for persons with high dissociative scores on the Dissociative Experiences Scale, Dissociative Disorder Interview Schedule, Structured Clinical Interview for Dissociative Disorder, and Lowenstein's Mental Status Exam (Schwartz, Galperin and Masters, 1995). On the other hand, Watkins and Watkins (1996, p. 446), who have pioneered ego state therapy claim, a relatively broad utilization of this treatment:

> Ego state therapy is an extension of understandings and procedures developed through the study of severe dissociation. ... It [ego state therapy] combines theoretical concepts originally proposed by Paul Federn with techniques of hypnoanalysis to develop a therapeutic approach that promises greater efficiency in the treatment of many normal, neurotic, and psychosomatic conditions, as well as in true multiple personality disorders.

Ego state therapy utilizes individual, family and group therapy techniques for the resolution of conflicts between the different ego states that constitute a "family of self" within a single individual (Watkins and Watkins, 1996). Consequently,
the "ego state therapist" attempts to access parts of the client's self that may overlap or have semipermeable boundaries, and works with and facilitates communication among the ego states. Ego state therapy utilizes a technique of abreaction with ego states which, according to Schwartz et al. (1995, p.46), "is of primary importance to any successful treatment of dissociated, sexually compulsive clients."

Schwartz et al. (1995) claim that effective therapeutic abreaction offers patients the opportunity to re-experience the traumatic events of their childhood from a new perspective combining their adult and child perspective. Ego state therapy offers other therapeutic techniques in addition to abreactive work such as the safe room technique, "cocoon" technique, and others. Such techniques facilitate communication and interaction between ego states. This facilitation increases boundary permeability and growth, and results in reduced dissociation. These conditions are usually achieved in the stage of integration characterized by cooperation in a mutually needs-meeting resolution of differences between ego states.

Art therapy

Cohen (1996) claims that in order to engage a dissociative survivor of childhood abuse in psychotherapy, one must use a language that the client finds effective. It seems that art activity may be a natural facilitator of the externalization of many aspects and outcomes of traumatic experience, since visual and sensorimotor functions are critical in the storage, coding, and recall of trauma. In addition, Cohen (1996) proposes that the traumatized individual lives in two different worlds: the realm of the trauma (past) and realm of "ordinary" life (present). These worlds are highly incompatible resulting in disparity, disruption and discontinuity in the lives of persons who have experienced chronic trauma.

Therefore, it seems that art reality can offer a relatively safe parallel realm to deal with the consequences of such incompatibility, while the use of metaphor and imagery in treatment may help the patients make sense of their worlds. In a similar vein, Cohen (1996) proposes a strong kinship between the art reality and dissociative reality as inherent qualities of both realms parallel one another. Both these realities appear to possess common characteristics such as plasticity, absorption, and multiple levels.

Cohen (1996) proposed a model based on a previously discussed BASK model (Braun, 1988) for structuring the art therapy process in the treatment of dissociative disorder clients. It is assumed that the phenomenon of separation or dissociation of any or all of the BASK levels also holds true in art. Therefore, Cohen's model (1996) parallels the four BASK levels (Behavior, Affect, Sensation, and Knowledge) in that it defines the facets of the art-making process as: kinesthetic-sensory, perceptual-affective, cognitive-

symbolic, and creative. In practice, any art-making activity, according to Cohen (1996), would engage all such facets that correspond to the BASK levels.

As a result of art therapy in the treatment of dissociation one can expect three different effects associated with one or more of the BASK levels. The restorative effect refers to the attainment of mastery over the past and relates to Affect and Sensation BASK levels. The orientative effect of art therapy is assumed to communicate new information about the person and her/his world and suggest ways for the integration of disparity within each. This effect is supposed to be associated with the Knowledge component from the BASK model. Finally, the preparative effect provides for the rehearsal of upcoming events and reinforcement of control in the present. Cohen (1996) proposes that the preparative effect can be associated with the Behavior BASK level.

Art therapy appears to be a potentially useful treatment technique for sex offenders with elevated dissociative levels. It seems that such therapy provides a very safe environment for patients and, additionally, offers them a non-verbal way of communicating trauma-related pain. It seems that art therapy may be a particularly useful initial component in the treatment of juvenile sex offenders with a history of abuse. Such a component may be, for those with severe emotional pain, a facilitating channel to language-based therapeutic interventions.

One has to bear in mind that the efficacy of art therapy for patients with dissociative disorders has not been formally evaluated. However, based on theoretical and clinical evidence, such therapy appears promising with regard to its potential employment in reducing dissociative pathology in sex offenders.

"The four C's" approach in the treatment of dissociative pathology

Steinberg and Schnall (2000) claim that various symptoms of psychopathology, or even entire psychological disorders such as depression, panic attacks, substance abuse, mood swings, etc, may be external manifestations of an underlying dissociative problem. Consequently, Steinberg and Schnall (2000) argue that external symptoms will diminish significantly or will be eliminated entirely once internal core dissociative symptoms are detected and treated properly. Steinberg and Schnall (2000) propose a therapy for persons with dissociative pathology that is based on four C's – ***C**omfort, **C**ommunication, **C**ooperation, and **C**onnection.*

This therapy is designed mainly for people with a traumatic past who have dissociated from it in order to survive. However, the four C's-based techniques can also help patients with less severe dissociation to accept their past while maintaining control over their emotional responses to painful memories. Steinberg and Schnall (2000, p. 255) describe their therapy, while addressing a potential client, as follows:

> What differentiates treatment for dissociation from the usual talk therapy is that it gives you a new way of relating to yourself on a deeply nurturant level. Its strategies help you to accept and respect the different sides of yourself by communicating directly with them in a comforting way and encouraging them to cooperate with each other and connect into a functioning whole rather than remain in conflict.

Comfort

Steinberg and Schnall (2000) believe that dissociative patients need two sources of comfort in order to bring dissociated memories and feelings out of hiding: internal (within themselves) and external (environmental). Unfortunately, it seems practically impossible to assure an external comfort requirement if "four C's therapy" is employed with dissociative sex offenders in correctional settings. However, such persons may be taught to utilize several self-comforting strategies to achieve internal comfort. These strategies are: use of selected reading that teaches patients how to parent themselves; simple grounding and distraction techniques; creative visualization; and employment of a self-comforting schedule.

Communication

Steinberg and Schnall (2000) claim that teaching "dissociatives" the ability to conduct positive dialogues with themselves is a necessary therapy component. The chief goal of this component is to help patients built an inner voice that can respond effectively to the voice of fear, rage, sadness, or disparagement within themselves that resulted from trauma or abuse. This aim may be achieved by the use of various personalized mission statements. The main theme of such statements is the sense of responsibility that dissociative patients have for their different parts, and how these parts need to work together to end the state of being detached and bring about wholeness.

Correction of distorted thoughts is yet another technique within "four C'c therapy." Some types of cognitive distortions in dissociative patients, proposed by Steinberg and Schnall (2000), appear vaguely to resemble categories of cognitive biases

(e.g. overgeneralization) or cognitive schemas (e.g. perfectionism) originally proposed by Beck (1987). However, despite this resemblance, all types of cognitive distortions in "the four C's" therapy are trauma-related rather than general in nature. One might expect that a skill of correcting distorted thoughts may be relatively simple to implement in the treatment of dissociative sex offenders, as most programs for such offenders have a component called "challenging dysfunctional cognitions" (Hudson et al., 1998, p. 20).

Steinberg and Schnall (2000) also advise teaching dissociative patients how to have internal dialogues with the hidden parts of themselves. Such internal dialogues can be done silently, out loud, or in writing. Steinberg and Schnall (2000) claim that such internal communication can be a powerful tool for clearing up cognitive distortions about love, for example, "Love means getting hurt." Again, this particular aspect of internal dialogues appears to be similar to the component of the programs for sex offenders that teaches them relationship skills (see Hudson et al., 1998). Therefore, such similarity may be potentially helpful in incorporating the internal dialoging technique into the relationship skills component.

Cooperation

According to Steinberg and Schnall (2000), cooperation occurs as a result of communication. In other words, patients are taught how to reconnect themselves to the feelings they had as a child. In addition, dissociative patients are instructed how to identify their "inner child" and make that child part aware of the presence of other parts.

As a result, parts previously disconnected from one another can begin to cooperate with each other on a consistent basis.

Connection

Steinberg and Schnall (2000) state that the final phase of "the four C's" therapy, the connection of a person's separate parts, is the unity that ultimately cures the disconnection of dissociation. It seems that the more a person has experienced respecting and accepting the memories and feelings bound up in each part, the less need there is for the dissociative symptoms (amnesia, depersonalization, derealization, identity confusion, and identity alteration) that maintained their disconnection.

Therefore, amnesia in formerly dissociative patients has outlived its usefulness as a retaining wall due to the flow and sharing of feelings and memory back and forth. Additionally, previously dissociative persons do not have the same need for depersonalization triggered by trauma-associated cues. This need is diminished once patients can accept that the abuse or trauma happened to them, not to some stranger from whom they have detached themselves. Moreover, the dissociatives who are able to distinguish the present from the past and feel safe no longer need to disconnect from familiar people and their home environment in the form of derealization. Additionally, Steinberg and Schnall (2000) claim that identity confusion is reduced when identity fragments within a person are connected. Finally, identity alteration that is usually present in persons with dissociative pathology appears to diminish in patients who achieve the final stage of "the four C's" therapy. In such patients seizing of control by

different parts occurs much less frequently, if at all, as a result of inner teamwork. In general, as a cooperation process progresses, all five dissociative symptoms further diminish or disappear entirely. At the same time, integration of the separate parts into a unified whole is completed, and the person whose identity was once a collection of estranged fragments is made whole (Steinberg and Schnall, 2000).

It seems that the types of therapy for dissociative sex offenders proposed above would be time- and resources-consuming. On the other hand, one has to bear in mind that only a fraction of the sex offender population is affected by dissociative pathology. Therefore, perhaps some therapeutic techniques that address dissociation may be implemented at low cost into programs for sex offenders.

"The four C's" therapy techniques appear to be particularly suitable for adult sex offenders due to some resemblance of such techniques to those that are currently employed in cognitive-behavioral treatments for sex offenders. On the other hand, art therapy for dissociation may be particularly appropriate for young sex offenders because of possible developmental-related limitations with respect to language-based therapies. In addition, with young offenders, there is great proximity between the original trauma and their therapy. Thus, art therapy, or at least some of its components, can be potentially useful in reducing post-traumatic and dissociative symptoms.

Finally, one has to be aware of the lack of formal evaluation of treatments for dissociative pathology. Hopefully, future controlled studies would evaluate the efficacy

of therapies addressing pathological dissociation. One might only hope that this research will show a reduction in dissociative symptoms in patients from the sex offending population as a result of such therapies. This in turn may possibly eliminate amnesia for the offense and denial of the offense in dissociative sex offenders. As a result, such offenders would be accepted for treatment and could be also more amenable to therapy.

Consequently, one might speculate that the level of empathy in dissociative sex offenders for their victims may increase because of the "disappearance" of dissociative disconnection between affect and other components of dissociation, according to the BASK model. Finally, it is also plausible that offenders who have received therapy for their dissociative symptoms would have lower chances of re-offending. This could be due to them not "employing" dissociative defenses in the initial stages of the offense process. Gains resulting from successful therapy for pathological dissociation in sex offenders are of a highly speculative nature. However, such gains, if found to be true, may contribute profoundly to the therapy and rehabilitation of men who sexually offend.

HYPNOSIS IN THE TREATMENT OF SEX OFFENDERS

DEFINING HYPNOSIS

Hypnosis has been defined as follows:

> a procedure during which a health professional or researcher suggests that a client, patient, or subject experience changes in sensations, perceptions, thoughts, or behavior. The hypnotic context is generally established by an induction procedure (Kirsh, 1994, p.143).

There is widespread agreement within the field that hypnosis is not a form of therapy but rather an adjunct to therapy (Kirsh, Capafons, Cardena-Buelna, and Amigo, 1998). Therefore, it seems that hypnosis can be a technique utilized with many therapeutic approaches, for example, psychodynamic or cognitive-behavioral. As a result, hypnotherapy, as it is practised today, can be defined as the addition of hypnosis to accepted psychological or medical treatment (Kirsh, Lynn and Rhue, 1996). There are at least two characteristics of hypnosis that make this therapeutic tool potentially useful in the treatment of sex offenders: suggestibility (Spiegel, 1990) and imagery (Kirsh et al., 1998). In addition, Kirsh et al. (1998) claim that attributes of hypnosis like relaxation and imagery make hypnosis particularly compatible with behavioral and cognitive therapies.

POTENTIAL USE OF HYPNOSIS IN THERAPY FOR SEX OFFENDERS

There is a broad variety of specific hypnotic techniques. However, only a few hypnosis-based therapeutic tools that might be particularly suitable for dissociative sex offenders will be briefly reviewed here. The psychological literature that addresses the use of hypnosis/hypnotherapy with non-sex offenders and sex offenders was reviewed in Chapter I.

In summary, an approach utilized by Spear (1975), who employed hypnosis with 49 borderline recidivists, appears to be highly efficacious (post-treatment recidivist rate less than five percent) but also time-and resources-consuming. This study required special rooms with closed-circuit TVs with to and fro audio, office assistants, and pre-recorded tapes. Most participants received 15 hours of therapy. Two other experiments (Carich and Metzger, 1999; Guyer and Van Patten, 1995) appear to be less intensive with regard to the utilization of hypnosis. Carich and Metzger (1999), for example, employed with their subject only one hypnotic session that was introduced toward the very end of treatment.

Guyer and Van Patten's (1995) approach towards the use of hypnosis in the treatment of sex offenders appears to have many interesting aspects. Such use of hypnosis, if combined with cognitive-behavioral therapy tools, is hoped to enhance the treatment efficacy for dissociative sex offenders. A hypnotic element for dissociative sex offenders, proposed below, is generally based on Guyer and Van Patten's (1995) hypnotic procedures for incest offenders. The main resemblance between the two approaches lies in the use of hetero-hypnosis, in particular, techniques of hetero-hypnosis such as age progression and post-hypnotic suggestions. Guyer and Van Patten

(1995) also suggest teaching offenders auto-hypnosis, but that is not included in the hypnotic component proposed here. It is a concern that auto-hypnotic skills acquired during the therapy could be utilized by some sex offenders for "rehearsing" deviant fantasies rather than for treatment purposes.

Before using hypnosis in therapy it is necessary to assess sex offenders with respect to their hypnotic susceptibility (see Meyer, 1992). In general, all offenders with elevated dissociative scores are also expected to be good hypnotic subjects (Nash and Lynn, 1986). However, the utilization of proper hypnotic susceptibility scales rather than relying on offenders' dissociation scores is strongly advised. Such advise is based on Whalen and Nash's (1996, p. 197) research claiming a low correlation between hypnotizability and dissociativity and suggesting that these two traits "seem to exist fairly independently of one another." In practice, such a claim means that some dissociative persons may not be susceptible to hypnosis, and conversely, some patients with low dissociative scores may be highly hypnotizable. Therefore, employment of measures of hypnotizability can assure that only offenders selected with the use of such measures will be eligible for a hypnotic component in their treatment.

The second phase of the hypnotic element involves the education and orientation of the offender to the hypnotic procedures to be used. Thus, the myths of hypnosis and different hypnotic phenomena are discussed. Moreover, in this phase the therapist assesses fears of hypnosis, expectations, and fear-phobic responses in general. A good rapport between the therapist and offender can hopefully be established in this stage as trust appears to be necessary in the successful implementation of hypnotic techniques.

The next phase is focused on the development of hypnotic skills in the offender through hetero-hypnosis sessions with the therapist. This thesis proposes that the hetero-hypnosis element may be utilized in several components of cognitive-behavioral programs for sex offenders. However, two particular components of the program used at Kia Marama, New Zealand (Hudson, Wales and Ward, 1998) appear to be excellent candidates for incorporation of the hypnotic component.

First, it seems that hypnosis can be utilized during the assessment stage. A hypnotic trance may be employed to explore the circumstances of the offense(s) in the case of amnesia for the offence or denial of the offense. Additionally, hypnosis may be helpful in recovering offenders' own childhood trauma by creating a safe milieu for a disclosure. Finally, hypnosis may be an excellent aid with regard to assessing a history of offending, in particular first deviant sexual activities.

Second, the efficacy of the relapse prevention stage of the program for men who sexually offend may be enhanced by addition of the hypnotic element. In this stage, participants, amongst other tasks, present their increasing understanding of their offense chain and describe the skills that they have acquired to manage the relapse issues inherent in this chain. In general, this module further assists each offender in identifying internal and external factors that put him at risk and connecting these factors to adequate coping responses (Hudson et al. 1998). Therefore, hypnotic sessions appear to provide a good "rehearsing" opportunities for various non-offending scenarios (e.g. avoiding high-risk situations, avoiding the relapse despite having entered high-risk situations). In other words, hypnosis would be an excellent way for offenders to practise how to avoid all possible dangers in the offense chain. Hypnotic sessions could be conceptualized in

futuristic terms as "virtual reality offense chain video games" in which a non-offense outcome can be achieved with the guidance and help of the therapist. Finally, hypnotic techniques such as age progression and post-hypnotic suggestions might be introduced to the relapse prevention stage. The content of posthypnotic suggestions should be concerned with intended therapy goals (e.g. victim empathy, relationship skills). The age progression technique enables the therapist to project the client into the future. Various scenarios, previously discussed with the offender, with respect to positive goals in his/her life after being released from prison, may be "practiced" by means of this technique. Yapko (1985, p. 93) describes hypnotic age progression as the

> means for building positive expectations for the future. The hypnotized client is encouraged to experience positive future consequences arising from changes and decisions being made currently, concurrently; ... the client is encouraged to fully experience the scenarios and reap the benefits of having taken active and effective steps on his or her own behalf.

Hypnotic age progression may be facilitated by utilization of the hypnotic "as if" technique developed by Carich (1991) where the client is projected into his future through pretend statements containing "as if/what if" phrases.

In general, it is my assumption that the inclusion of the hypnotic component into treatment programs for male sex offenders may increase the efficacy of such programs and as a result decrease the rates of re-offending. This thesis proposes that the hypnotic component of the therapy may be particularly suitable for offenders with elevated scores on hypnotizability and, possibly, dissociative measures. My hypothesis regarding the

enhanced efficacy of programs including a hypnotic element is also based on current psychological research. Kirsh et al. (1998, p.4), for example, state that:

> Excluding treatments for obesity, the mean effect size for adding hypnosis to the treatment protocol was 0.52 standard deviations, indicating that the average client receiving cognitive-behavioral hypnotherapy showed greater improvement than 70% of clients given the same treatment without hypnosis.

However, this hypothesis about enhancing the efficacy of treatment programs for sex offenders by including a hypnotic component should be evaluated by means of controlled research. After all, offenders are a highly specific population. As a result, the therapist can face serious difficulties with respect to their compliance with hypnotic techniques, which are often seen as controversial even in the non-offender population. Finally, one has to remember that:

> There is nothing miraculous about the trance state. It has many values; but it does have limitations in terms of the individual's existing motivations and his capacities for change. Therapeutic failures occur with hypnosis as with any other form of therapy (Wolberg, 1948, p. 418).

CONCLUSION

Examinations of the psychological literature regarding pathological dissociation in male sex offenders indicate a strong presence of dissociative pathology in this population. However, further controlled research appears to be necessary in order to confirm that such prevalence is significantly higher than that in the general or clinical populations. This thesis argues that the above findings created a legitimate base for further exploration of issues related to the presence of pathological dissociation in the sex offender population. These issues are: etiology of pathological dissociation in sex offenders (childhood trauma); presence of dissociative states in the sexual offense process (model); and treatment implications for dissociative sex offenders. The final conclusions of this exploration are presented below.

Etiological factors of dissociative pathology in male and female sex offenders were thoroughly explored. The psychological literature appears to indicate strongly that childhood trauma is the chief etiological factor contributing to the development of dissociative pathology in the sex offender population. Some literature, however suggests other minor pathways in the acquisition of adult pathological dissociation. These pathways were not discussed in this thesis due to space limitations. Additionally, all the psychological research reviewed here acknowledges that the prevalence of

childhood sexual, physical, and emotional trauma in male and female sex offenders is significantly higher than that in the normal population.

Consequently, a model of dissociative pathology in the sexual offense process in adult male sex offenders was proposed. It is possible that the models of dissociation in female sex offending or juvenile sexual offending may have several similarities to the model theorized in this thesis. However, the development of such models requires intense research efforts. The model proposed here assumes that dissociative states can be present in most stages of the sexual offense process. However, it seems that dissociative processes may cease in some offenders in the post-offense evaluation stage of the offense process.

It appears that the model proposed here can account for phenomena present in some offenders such as amnesia for the offense, denial of the offense or lack of empathy for the victim. The model of dissociation in the sexual offense process was compared to and contrasted with the cognitive deconstructionist interpretation of cognitive distortions and affective deficits in sex offenders. Such comparisons were extremely helpful with respect to the validation of the model of dissociation in sex offending. This validation also indicates that the model proposed here can account for many phenomena present in sex offending. However, well-controlled research is necessary to validate the model.

Finally, implications for therapy for adult male dissociative sex offenders were discussed. First and foremost, it has been proposed that addressing childhood trauma in the treatment of sex offenders is imperative. By dealing with childhood abuse issues one would expect alleviation of dissociative and other symptoms of psychopathology

present in sex offenders. Several therapeutic techniques for addressing dissociative pathology in men who sexually offend were critically reviewed. It was concluded that "the four C's" therapy may be particularly suitable for incorporating into treatments for sex offenders. Moreover, addition of a hypnotic component to current cognitive-behavioral programs for sex offenders was proposed. Support for the particular suitability of this therapeutic technique for sex offenders was based on research indicating their higher hypnotizability. Additionally, the prevalence of pathological dissociation and childhood trauma in this group is higher than in the general population. The utilization of hypnosis in stages of treatment for sex offenders such as assessment and relapse prevention was proposed.

One may ask why this thesis is preoccupied with clinical issues with respect to *persons who sexually offend* but not *victims of sexual offending.* It could be argued that victims of sex crimes do not receive enough attention, support or therapy. It was not my intention to insinuate in any way that sex offenders deserve more psychological research attention than victims of sex crimes. I would like to acknowledge here the pain and suffering of persons who have become victims of sexual offending. I believe that they deserve all available psychological resources in order to alleviate their suffering related to sexual abuse.

My intention was to bring the attention of psychologists and mental health professionals to the issue of dissociation in sexual offending. It was not my intention to imply that pathological dissociation in sexual offending is an excuse for such offending behavior. I have suggested that assessment of dissociative pathology and consequently treatment of dissociative symptoms could be beneficial for persons who sexually offend. Such

persons may then be able to profit more fully from available programs and as a result avoid re-offending.

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