Número 12

Psiquiatria, Psicologia & Justiça

Julho de 2017

Sociedade Portuguesa de Psiquiatria e Psicologia da Justiça

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Crime and Self-Complaint: Why?

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The authors do not have financial, personal, or professional conflicts of interests. The study was conducted according to APA ethical standards.

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Abstract

We met contact with this case report through the media and all information about this case came from there. Five years after having committed two murders, the murderer turned himself in. The first murder occurred as a result of an attempted theft of a car, with the victim being a 33-year-old woman, who resisted the attempted theft of her car; the second was of a 21-year-old man, in the early hours of the following day, apparently, because, as an employee of the park where the attempted car theft occurred, the victim tried to prevent the crime that was being committed. The victims were unknown to the killer. We equate the reasons, including psychopathology, which may be determined and compared with the theoretical hypotheses, which effectively determined the self-denunciation of the murderer, taking into account the role of emotions of guilt and shame.

Keywords: mental health, recidivism, juvenile delinquency, forensic psychology, homicide

Crime and Self-Complaint: Why?

Society seeks to instill moral values so that the individual internalize their prosocial behaviors to a record. Furthermore, society resorts to punishment to discourage people from committing crimes.

Shame and guilt are emotions with relevance to the field of Psychology (Elster, 1999; Tangney et al., 2007), and specifically to human thinking, feeling, and behavior. They have often been used by those who work with forensic populations to describe the emotional response of an individual to his offence (Almeida, 1999). It has been suggested that the two types of reaction differ in their implications for the behavior of the offender (Tangney, Stuewig, & Hafez, 2011). E.g., feelings of shame in response to committing a crime have been hypothesised to impede confession, while it has been suggested that feelings of guilt facilitate this process (Wright & Gudjonsson, 2007). However, the reactions are not as linear as previously explained, knowing that there are individuals whose guilt is overwhelming in such a way they can not confess their crime and even commit suicide before its revelation. The emotions are generally considered as quintessential “moral” emotions because of their assumed roles in inhibiting immoral, socially undesirable behavior, and in fostering altruistic, prosocial behavior (Tangney, Stuewig, Mashek, & Hastings, 2011). Conversely, serious persistent deviation from moral and societal standards reflects a fundamental impairment in the capacity to experience shame and guilt (Tangney et al., 2011), or the deviation might be in excess where the individual feels excessive guilt and/or shame as a result of a severe mental disorder (delusional).

The moral emotions of shame and guilt have been assumed to play an important role in restraining people from committing crimes (Rebellon et al., 2010; Tibbetts, 2003). It is assumed that we do everything we can to avoid the painful feeling of the two emotions (Elster, 1999; Tangney et al., 2007). A large number of studies have reported a negative association between offending and the feeling of shame or the feeling of guilt (for example, Loeber et al., 1998; Rebellon et al., 2010). Additionally, there is empirical evidence that moral emotions like shame and guilt can be seen as a consequence of the socialization process (Grusec, 2011; Tangney & Dearing, 2002).

Shame has been defined as one of the most important, painful, grievous, and intensive of all emotions (Elster, 1999; Lewis, 1992; Scheff, 1997; Tangney, 1995). Shame emerges when individuals commits an act that violates internalized norms and feels that has failed to live up to the norms of the group (Elster, 1999; Svensson, 2004). It is not the act in itself that is important to the person, it is the way has he lives the act he committed (Tangney et al., 2007). Guilt is considered by Elster (1999) as less painful than shame since the emotion of guilt is related to a specific act whereas shame relates to the individual's perception of the self through the eyes of others and of these others' disapproval.

The moral emotions of shame and guilt emerge during the process of primary socialization. In this process family is essential for the development of these emotions (Barrett, 1995; Lewis, 1992; Sheikh & Janoff-Bulman, 2010). These emotions may be consolidate or adjust during the secondary socialization through school and the peer group (Elkin & Handel, 1989; Gecas, 2000). Individuals receiving sharp parental support and subjected to love-oriented technics of parental control internalize norms and learn

moral values better than individuals not receiving this values, and in the future they will feel more shame and guilt when they violate rules (Abell & Gecas, 1997; Grusec, 2011; Tangney & Dearing, 2002). School is also very important in this process of feeling shame, guilt, and remorse. Students who are committed to school will be more receptive to the expectations of teachers, who are usually law conforming (Hirschi, 1969; Maddox & Prinz, 2003). However, interaction with deviant peers may affect the process of adapting anticipated shame and guilt in a different way. Thus, an individual's moral values may be influenced by the attitudes and beliefs of peers (Sutherland, 1947; Megens & Weerman, 2012). Individuals also may anticipate feelings of guilt and shame for non-offending when they believe that offending is needed to demonstrate loyalty to friends and to prevent ridicule (Warr, 2002). If the socialization process is completed, norms will be internalized and the individual will develop a moral sense of what is right or wrong (Berger & Luckmann, 2010; Palacios & Brodzinsky, 2010). The feeling of shame will restrain individuals because they fail to live up to the standards of the group and the fear of guilt will contain individuals from committing a crime because the individuals themselves view that as an act morally incorrect (Harris, 2011; Svensson, 2004).

However, our decades of clinical experience leads us into believing that guilt is more powerful than shame, because guilt is carried within the subject to anywhere, regardless of shame. While the shame of criticism/reproach can be dimmed by the absence of the other, guilt never is. Moreover, guilt leads to another form of shame: shame not only of what the other thinks about the subject, but shame of themselves, which does not require disapproval from the other, being permanently carried by the subject, regardless of being alone or not. This shame in oneself is impregnated and is

almost indistinguishable from guilt, without overlapping, although it may be concomitant, with shame in relation to another. We did no work to confirm that guilt is more painful than shame (as we mentioned, we believe this results from clinical experience). However, we cannot forget the existence of another powerful feeling: remorse. Remorse is deeply related to guilt, is a by-product of guilt, is embodied in a disapproving rumination and, when intense and obsessive, can be very powerful. Remorse can undermine the individual's consciousness, even when the behaviors of the subject are unknown to each other, working inside the individual and determining behaviors like suicide or self-complaint.

A descriptive case study will be conducted in order to answer the objective of this study: equate the reasons, including psychopathology, which may be determined and compared with the theoretical hypotheses, which effectively determined the self-denunciation of the murderer; and discuss whether or not he can be considered not guilty by reason of mental illness.

Case Report

The murderer turned himself in to the police on November 21st of 2013, five years after committing two murders. We met contact with this case report through the media and all information about this case came from there.

The first murder occurred on February 29th of 2008, as a result of a carjacking attempt. The victim, a 33-year-old woman, was killed after resisting the murderer's attempt to steal her vehicle. The second murder happened during the first hours of the following day, after the victim, a 21-year old male employee of the park where the

carjacking attempt took place, witnessed the situation and tried to prevent the crime from being committed. The victims were allegedly unknown to the killer.

In defending the thesis of considering the murderer guilty of his crimes we should state: a) the murderer had a normal family, social and working life at the time he committed the crimes; b) the crimes of theft he planned had a utilitarian character, with the crimes of murder emerging as a result of the triggering of the primary crimes; c) he hid for five years the crimes he committed; d) he displayed appropriate behavior after the perpetration of the crimes. Moreover, he was married and his wife had never suspected the crimes he committed; e) he maintained, in subsequent years, an apparently normal behavior and when he turned himself in he was depressed, despite having, as everything indicated, a clear awareness; f) the justification he gave for his crimes was that of someone who experienced those crimes with a lot of guilt, which could indicate that the subject did not find excuses within himself, such as mental illness, for the crimes he committed.

Accordingly to Article 20. of the Portuguese Penal Code: 1) A person is unimputable if, by virtue of a mental disorder, they are unable, at the time of committing the act, to assess its unlawfulness or to determine themselves in accordance with that assessment. 2) A person can be declared unimputable if, by virtue of a severe mental disorder, non-accidental and whose effects they cannot control without thereby possibly being censored, they have, at the time of committing the act, the capacity to assess its unlawfulness or to determine themselves in accordance with that significantly reduced assessment. 3) A proven inability of the agent to be influenced by the sentences may constitute an index of the situation referred to in the preceding paragraph. 4) The

unaccountability is not excluded when the mental disorder has been caused by the agent with the intent to commit the act.

Results

1. The subject experiences the crimes with guilt, he cannot break free of guilt without atonement. In this circumstance, the murders would have been committed:

a. Accidentally (the victim was killed by chance, for example, hit by a car following an escape);

b. The murder was an additional and unexpected crime given that it was not expected that the murder victim would be found at that time and place, either witnessing or preventing the execution of the premeditated crime (which was not the crime of murder, but of theft or rape, for example). In these circumstances, the murder will be experienced in an ego-dystonic manner, originating guilt, remorse, shame, and can lead to obsessive ruminating, which the subject cannot release and can be exacerbated by multiple experiential factors. In this case, the killer feels deserving of punishment and must answer for the crimes committed, which can trigger self-reporting.

2. The subject knows that he continues to be sought after by the police, and he experiences with extreme anguish his escape of justice, as well as the possibility of being caught at any given moment, a thought that constantly assaults him. The request to go meet new inquiry, the reports that the investigation continues and surrounds him, etc., may lead to self-reporting as the price to pay for a less anxious life, for life in which the subject is physically incarcerated but mentally free, as opposed to a life in which he is physically free, but mentally imprisoned in the distress from which he cannot escape.

3. The murderer has become depressed as a result of a set of experiences that cause depressive symptoms (as potential causes: divorce, unemployment, his own or his relatives' sickness, financial difficulties, etc.) he envisions his life as a sequence of events included in a suffered an unfortunate trajectory, he views himself as a worthless person on a path without hope, his homicides contaminate his mind in a more pronounced and unbearable way, so as to justify an atoning decision.

4. The murderer's life has been problematic and the subject believes that there is a supernatural influence (possibly divine) that will never allow him to be happy until he atones for his crime.

5. The subject suffers from a psychosis, namely a schizophrenic psychosis or paranoid psychosis, and is suffering from a psychotic crisis during which he has less control over his behavior, thus, verbalizing his crimes.

6. The subject experiences a maniac outbreak, during which he loses behavioral control and verbalizes what he would never verbalize in the absence of this pathology.

7. The subject suffers from a major depression, experiences feelings of hopelessness coupled with marked subjective distress, as well as a feeling that all is lost (it may or may not have psychotic contours) and also the conviction that the world deserves to know who committed the crimes (and shall pay for them).

8. The man suffered a traumatic brain injury (TBI), particularly in the frontal area, which determined changes in his character and/or cognitive functioning, with decreased ability to adapt his behavior to his interests.

9. In consequence of an organic disorder (dementia, cancer, endocrine changes, etc.), the subject suffered modifications in his character and/or cognitive functioning, with decreased ability to adapt his behavior to his interests.

10. The subject denounces himself during a phase in which he is under the toxic effect of a disinhibiting substance (most likely, alcohol, cocaine or amphetamines).

11. The subject suffers from a personality disorder in which the narcissistic need to emerge from anonymity and show himself to the world is prevalent, even if it means paying the price by means of imprisonment.

12. The subject operated as a result of a sense of mission, which he now does not endorse and, hence, he regrets the crime he committed and decides to pay the price of his past behavior. There might exist here a pro-social (re)conversion.

13. The subject suffered in the past psychotic crisis and the subject denounces himself in a phase where he is mentally healthy and wants to atone for crimes he committed whilst in a psychotic phase (e.g., mystical or persecutory delusion).

Discussion

Shame, remorse, and guilt play an important role in criminal prevention. Individuals without these feelings (e.g., people with marked psychopathic traits) have more propensity to criminality because these feelings are attenuated or absent. Is reasonable the murderer reported here can suffer from shame, remorse, and guilt enough to determine is behavior and/or his psychopathology, which originated self-complaint.

Bearing in mind the assumptions made, it would be essential to know how the homicides occurred, as well as the personal and psychiatric history of the murderer.

The aforementioned tells us that the victims were unknown to the killer and the homicides occurred in a context where, as everything indicates, they were not desired, thus constituting additional crimes that the murderer had to commit to achieve his goals (theft) and not be reported. Although the crimes of car theft had been premeditated, which implies a planned action, accepted by the subject and objectified for a particular result, there is no guarantee that the homicides were also premeditated, or at least regarded by the criminal as an equitable or acceptable possibility. Consequently, we do not neglect the possibility of the homicides having occurred during an impulsive state, determined by feelings of anger or fear. Following the previously stated, if the homicides were not premeditated or regarded as an acceptable possibility for the subject, the likeliness of them being felt as ego-dystonic increases considerably, leading to subsequent discomfort, distress, remorse, guilt, etc. In these circumstances, the probability of the subject dwelling on guilt, which could prove overwhelming and culminate in self-reporting, increases substantially, despite having elapsed years (five in this case) of concealment.

That's exactly what happened, the killer turned himself in because he confessed. The murderer, who was married and was a security worker, when he surrendered, he handed in the firearm that perpetrated the crimes, and said he could no longer live with the remorse without paying for the crimes he committed.

The analysis of this case does not end here, however. Indeed, it is important to understand if the subject, at the date the crime was committed, was suffering from a mental disorder that met the criteria defined in Article 20. of the Portuguese Penal Code.

Theoretically, there are considerations that should be equated as favorable to the defense of the Not Guilty by Reason of Insanity (NGRI) or guilty (responsible by the crimes) thesis. Regarding the defense of NGRI of the subject, we should highlight the criminal's history of psychiatric treatment and abandonment of said treatment a few months before he committed the crimes. It would be equable, in the defense of this hypothesis, that the subject was in a crisis of a mental disorder, namely, a psychosis, which prevented him from exercising proper control of the assessment of illegality, which seems unlikely given that he fled after committing the crimes which, as should be noted, he silenced; the NGRI could still be assigned before the demonstration that, as a result of a mental illness, he was unable to determine himself in accordance with the assessment of illegality, or that he had, as a result of severe mental illness, this capacity significantly decreased, as laid down in law.

We think that he will be considered guilty of the crimes he committed.

Limitations

We would like to have a more rigorous clinical, social, familiar, and criminal story of this individual but our knowledge from this case is limited because information came from media.

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Aspetos Psicopatológicos e Médico-legais do *Stalking*

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Resumo

Introdução: O *stalking*, pode ser definido por um padrão de comportamentos de perseguição e/ou assédio persistente e repetitiva, nomeadamente sob a forma de aproximação furtiva, comunicação e contacto não consentidos, vigilância e monitorização de uma pessoa-alvo. Recentemente foram notáveis os esforços de uniformização e caracterização do conceito de *stalking* no âmbito legal, que culminaram na sua criminalização em Portugal. Objetivos: Revisitar o conceito de s*talking,* a sua definição*,* tipologia das vítimas e agressores, com destaque especial para as considerações psicopatológicas inerentes, os aspetos médico-legais e revisão do enquadramento legal do s*talking* em Portugal. Métodos: Revisão não sistemática da literatura. Resultados e Discussão: As considerações sobre a psicopatologia do fenómeno abrangente que é o *stalking* são escassas. Na sua esmagadora maioria, tais comportamentos são enxertados em perturbações de personalidade, cuja responsabilidade criminal não se encontra diminuída. Apenas em escassos casos, estes se associam a perturbações psiquiátricas passíveis de serem associadas à presença de pressupostos médico-legais de inimputabilidade, nomeadamente os quadros psicóticos. Nestes últimos casos, a inimputabilidade pode ser considerada. Deste modo, a distinção fenomenológica é fundamental não apenas no âmbito clínico mas também forense.

Palavras-Chave: *Stalking*, Psicopatologia, Psiquiatria Forense, Responsabilidade Criminal

Aspetos Psicopatológicos e Médico-legais do *Stalking*

As definições existentes para o *stalking* diferem de acordo com o país e legislação em vigor. Mais recentemente começou a ser reconhecido em vários domínios: científico, social, jurídico-legal e médico. Atualmente, o *stalking*, define-se como uma forma tipificada de violência interpessoal, que consiste num padrão de comportamentos de perseguição e/ou assédio persistente, não consentido e indesejado, que se traduz em formas diversas de aproximação, comunicação, contacto, vigilância e monitorização de uma pessoa-alvo, de forma a aterrorizá-la e constranger o seu comportamento e liberdade de determinação (Kamphuis & Emmelkamp, 2000; McEwan & Strand, 2013; Matos et al., 2012; Spitzberg. & Cupach, 2007). Pese embora o facto de alguns autores portugueses recorrerem à expressão "assédio persistente" como tradução portuguesa, e do termo "perseguição" ter sido acolhido na epígrafe legal do crime, os autores são da opinião de que ambas expressões, isoladamente, não representam uma tradução conceptual satisfatória do fenómeno, capaz de o abranger nas várias vertentes, optando assim, pela utilização da expressão anglo-saxônica original. (Matos et al., 2012) A dificuldade da conceptualização do fenómeno poderá ser explicada pela sua natureza insidiosa e heterogénea, uma vez que existem diferentes tipologias de vítimas e agressores, diferentes motivações, e as estratégias utilizadas pelo *stalker* podem assumir inúmeras formas distintas (Sheridan et al., 2003; McKenzie & James, 2011; Owens, 2015). Os comportamentos de *stalking* admitem graus variáveis de severidade, desde atos mais rotineiros e aparentemente inofensivos (envio de mensagens escritas, telefonemas repetidos, envio de presentes, graffitis, notas deixadas no veículo da vítima, fotografias furtivas) até ações mais ameaçadoras e intimidatórias (perseguição, ameaças e agressões psicológicas, físicas e/ou sexuais) (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; Tjaden & Thoenness, 1997). O *stalking* pode ter uma duração breve ou mais prolongada no

tempo. A maioria das definições sublinha a evidência de comportamentos com carácter repetitivo e persistente, que evocam na vítima um sentido subjetivo de medo e de ameaça. Uma característica da sua potencial perigosidade, prende-se com o tempo de duração deste tipo de conduta, uma vez que, ao prolongar-se no tempo, tende a escalar em frequência e gravidade. Em alguns casos, a violência pode escalar até culminar no homicídio da vítima (Ostermeyer et al., 2016). Num estudo internacional relativo a uma amostra forense que incluiu indivíduos acusados de crimes de assédio e ameaça, cerca de 21 a 25% dos casos forenses de *stalking* culminam em violência significativa (Harmon et al., 1995). Comportamentos de *stalking* podem também ser perpetrados pelos agressores recorrendo a suportes de comunicação eletrónica, nomeadamente o recurso à internet, constituindo assim uma forma mais sofisticada de perseguição: o *cyber-stalking* (Southworth et al., 2007; Drebing et al., 2014). Esta última permite aos agressores ultrapassar barreiras geográficas e trabalhar em anonimato, dificultando assim a sua localização. Este fenómeno enfrenta várias limitações respeitantes ao seu processo de validação sociocultural e judicial. Em alguns países na Europa, o *stalking* ainda não constitui uma ofensa legal distinta, o que dificulta a sinalização e monitorização sistemática destes casos (Kamphuis & Emmelkamp, 2000). Os dados que estimam a sua prevalência e incidência são em escasso número e originários sobretudo de estudos americanos, onde a taxa de prevalência para a vitimização ao longo da vida, é de aproximadamente 12 a 16% em mulheres e 4 a 7% em homens (Sheridan et al., 2003; McKenzie & James, 2011). Em contexto nacional, dados recolhidos através do *Inventário de Vitimização por Stalking* (Matos, Granjeia, Ferreira & Azevedo, 2009), num estudo baseado num amostra representativa da população portuguesa, 19,5% dos participantes referiu ter sido vítima de *stalking* em algum momento da sua vida. (Matos et al., 2012). Mais recentemente, os resultados do estudo da Agência para os Direitos Fundamentais da União Eu-

ropeia (FRA, 2014), que procedeu à recolha exaustiva de dados sobre a violência contra as mulheres, em 28 estados-membro (UE-28), incluindo Portugal, revelou que 18% das mulheres experienciaram *stalking* desde os 15 anos de idade, e 9 milhões de mulheres na UE-28 foram vítimas de *stalking* nos 12 prévios à realização desse estudo. A obtenção de dados relativos à prevalência e incidência deste fenómeno poderá ser dificultada pela inconsistência da definição e limitação do conceito (Owens, 2015), no que diz respeito a que comportamentos são entendidos por *stalking*, quais as consequências que asseguram o papel de vítima, a duração mínima e frequência de comportamentos (Sheridan et al., 2003; Whyte et al., 2008). Taxas de prevalência podem ainda ser contaminadas por falsos relatos de vitimação (Sheridan et al., 2003). Com efeito, no contexto internacional, mesmo nos países em que a criminalização do *stalking* foi reconhecida há vários anos, o fenómeno prevalece subreportado e subnotificado (Brady & Nobles, 2015).

Método

Objetivos

Ao longo deste artigo, os autores partindo da definição de *stalking* na introdução, visam uma análise geral do perfil das vítimas e agressores, assim como, a exposição e debate das considerações psicopatológicas mais frequentes, alertando para a importância da distinção fenomenológica e os aspetos médico-legais inseparáveis deste fenómeno.

Material e Procedimento

Os autores efetuaram uma revisão não sistemática da literatura através da consulta das bases de dados eletrónicas - MEDLINE/ PubMed e outras obras relevantes, nomeadamente manuais e documentação de apoio a profissionais de saúde. Foram utili-

zadas as palavras-passe: *Stalking*, psicopatologia, Psiquiatria Forense e responsabilidade criminal. Foram pesquisados estudos escritos em Inglês e Português.

Resultados

Tipologia das vítimas

Qualquer pessoa pode ser vítima de *stalking* em algum momento da sua vida, não constituindo as vítimas um grupo homegéneo (Sheridan et al., 2003). No entanto, as vítimas de *stalking* são, na sua maioria, do sexo feminino, e pertencentes à faixa etária entre os 18 e os 30 anos (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; Matos et al.,2011); McEwan & Strand, 2013; Southworth et al., 2007). Num estudo dirigido a uma amostra representativa da população portuguesa, em cerca de 40% dos casos, a vítima conhecia o agressor. Em 31,6% dos casos, os agressores corresponderam a parceiros/ex-parceiros da vítima (Matos et al., 2011), percentual inferior ao referido em estudos internacionais que apontam para até 80% dos casos em que existe um relacionamento íntimo atual ou prévio. (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; Melton, 2007). Frequentemente, existe um vínculo temporal entre o término da relação e o início do *stalking,* fenómeno que se reproduz em cenários quer nacionais quer internacionais. Também, história prévia de abuso é muito comum entre mulheres vítimas de perseguição, e sofrer de violência doméstica aumenta a probabilidade de ser vítima de *stalking* (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; Tjaden & Thoenness, 1997). Para as vítimas de ex-parceiros, geralmente a vítima é do sexo feminino e existe uma maior probabilidade dos comportamentos de *stalking* ocorrerem durante um período mais alargado no tempo, em maior frequência, e com maior risco de violência íntima (Tjaden & Thoenness, 1997). Na verdade, a existência de uma relação íntima é considerada o fator preditor mais significativo de violência (Mullen et al, 1999; Ostermeyer et al., 2016). Outros fatores preditores de violência significativa documentados são: com-

portamentos intimadatórios/ameaças, uso de substâncias, história prévia de violência, antecedentes criminais, presença de perturbação da personalidade *cluster* B e ideação suicida por parte do *stalker* (Mullen, 1999; Farham et al., 2000; Ostermeyer et al., 2016; Dressing et al., 2007). Também pode ocorrer entre vítimas masculinas e agressores do sexo feminino ou entre ex-parceiros do mesmo sexo (Purcell et al., 2001).

Face à heterogeneidade das vítimas, Mullen, Pathé e Purcell (Apud *"Stalking: Psychiatric Perspectives and Practical Approaches"*, 2007), procuraram categorizá-las de acordo com o contexto em que ocorre o *stalking* e a relação da vítima com o *stalker*. As vítimas podem ser classificadas como: a) conhecidas ou amigas do *stalker* (neste caso, os *stalkers* procuram de forma disfuncional estabelecer uma relação de intimidade, mais frequentemente após um encontro casual e geralmente sofrem de escassas competências sociais); b) vítimas em contexto de relações profissionais de apoio que pela sua proximidade e contacto regular, poderão apresentar um risco acrescido de *stalking* (profissionais de saúde, assistentes sociais, professores, entre outros); neste grupo, os comportamentos de *stalking* surgem geralmente após o fim da relação profissional que é percecionado como abandono e rejeição; c) vítimas em contexto laboral, o *stalking* pode envolver qualquer indivíduo da pirâmide hierárquica, pelos mesmos motivos (entidade patronal e subordinados, clientes e colegas de trabalho); d) vítimas por desconhecidos e) vítimas celebridades: políticos, apresentadores de televisão, atores, e/ou desportistas, constituem um alvo fácil para os *stalkers* pela sua exposição mediática (Sheridan et al., 2003; Matos et al., 2011). As celebridades vítimas são muitas vezes perseguidas com o intuito de estabelecer uma relação de intimidade, vingança ou obtenção de favores. (Matos et al.,2011) Os comportamentos de *stalking* provocam nas vítimas, por definição, sentimentos de medo e insegurança que são mais severos quando o perpetrador é do sexo masculino (*versus* sexo feminino), desconhecido (*versus* conhecido da vítima),

se existem condutas heteroagressivas (*versus* comportamentos de perseguição) e na presença de maior duração de comportamento (*versus* menor duração) (Podaná & Imríšková, 2014). Existem alguns casos de "falsas vítimas" que correspondem a troca de papéis, em que o *stalker* acusa a vítima de o perseguir, de forma a manter um contacto legal com a mesma (Matos et al., 2011). Falsos relatos de vitimação podem ter o propósito de obter ganhos secundários, ou serem o resultado de experiências prévias traumáticas. Ex-vítimas podem percecionar comportamentos neutros como *stalking*, em contexto de hipervigilância e desconfiança generalizadas. Falsas vítimas poderão ainda corresponder a casos de perturbações psiquiátricas, devido à presença de ideias delirantes persecutórias e/ou atividade alucinatória.

Tipologia dos agressores

Várias taxonomias têm sido propostas por diferentes autores no que diz respeito às tipologias dos *stalkers*. Estes tendem a ser também caracterizados de acordo com as suas características psicológicas e de acordo com a natureza da relação agressor-vítima (Kamphuis & Emmelkamp, 2000). Relativamente à tipologia do *stalker*, a maioria é do sexo masculino e corresponde à figura de um ex-companheiro da vítima (Spitzberg. & Cupach, 2007; Dressing et al., 2006; Matos et al., 2011). Os ex-parceiros tendem a ser mais violentos do que os *stalkers* desconhecidos (Tjaden & Thoenness, 1997). Por esse motivo, a maioria dos autores concorda com a importância de distinguir os casos em que existe algum tipo de relação prévia entre a vítima e agressor, dos casos em que não existe qualquer tipo de relação real (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003). Relativamente aos parceiros íntimos, estes tendem a ser mais perversos no seu *modus operandi*, peritos na arte do controlo coercivo, têm mais antecedentes criminais associados a violência, história de consumo de drogas e/ou álcool, mas raramente apresentam sintomatologia psicótica (Sheridan et al., 2003; Logan, 2010; Matos et al.,

2011). Vários estudos sugerem um perfil "típtico" do *stalker*, que correspondente a indivíduos de sexo masculino, com idades compreendidas em entres 35-40 anos, geralmente desempregados, com antecedentes psiquiátricos e/ou criminais (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003). É comum também uma história de relacionamentos fracassados (Sheridan et al., 2003). Nem todos os *stalkers* atuam sozinhos ao contrário da ideia preconcebida sobre este modo de atuação. O termo "*stalking by proxy*" (por procuração), traduz as situações em que estão envolvidas outras pessoas no encalço das vítimas (Logan, 2010; Matos et al., 2011). Tais pessoas poderão recorrer a profissionais, investigadores privados, familiares ou até mesmo a/o nova(o) companheira(o). Este tipo de *stalking* é particularmente comum entre profissionais de saúde designadamente profissionais de saúde mental (Mullen et al, 2000). Vários sistemas de classificação dos *stalkers* foram propostos, com o objetivo de caracterizar a população de perpetradores, identificar preditores de risco de violência associados a grupos particulares e delinear estratégias de intervenção (Racine & Billick 2014). A classificação de Mullen e colaboradores distingue 5 subtipos de *stalkers*, reconhecidos por autores portugueses (Matos et al., 2011). Estes subtipos integram o contexto em que ocorrem os comportamentos, as motivações do *stalker*, características psicológicas e natureza de relação prévia com a vítima: o/a *stalker* rejeitado/a, o/a *stalker ressentido/rancoroso*, o/a *stalker em busca de intimidade*, o/a *stalker inapropriado* e o/a *stalker predador* (Sheridan et al., 2003; Whyte et al., 2008; Mullen et al., 2000; Mullen et al, 1999; Matos et al., 2011).

No caso do/a *stalker rejeitado/a*, o tipo mais comum, os comportamentos *stalking* surgem tipicamente após o término de uma relação íntima, e o/a *stalker* atua com o propósito de obter da vítima a retaliação, movido pelo desejo de vingança, ou eventualmente por uma complexa e volátil combinação de ambas as motivações

(Kamphuis & Emmelkamp, 2000; Whyte et al., 2008; McEwan & Strand, 2013; Matos et al., 2011). Este apresenta-se como o mais intrusivo e persistente de todos os *stalkers*, com maior risco de se tornar violento (Mullen et al, 1999; Catanesi et al., 2012). Em termos psicopatológicos, raramente apresenta distúrbios de natureza psicótica, no entanto, pode evidenciar graves distúrbios de personalidade relacionadas com sentimentos de posse, dependência, desconfiança e narcisismo. O *stalker ressentido/rancoroso* persegue a vítima movido pelo sentimento de vingança ou validação, após um episódio percecionado pelo próprio como negativo, por exemplo como uma injustiça ou humilhação. (Kamphuis & Emmelkamp, 2000; Whyte et al., 2008; McEwan & Strand, 2013; Matos et al., 2011). Em alguns casos poderá estar associado a um funcionamento paranoide ou narcísico de base. O *stalker em busca de intimidade (intimacy seeker),* ingressa em comportamentos *stalking* em busca de um relacionamento íntimo com a vítima que acredita ser o seu "amor verdadeiro", movido pela crença de um amor romantizado e idealizado. Geralmente as vítimas não têm qualquer relação com o/a *stalker,* por exemplo celebridades ou sujeitos que ocupam um estatuto social superior (kamphuis & Emmelkamp, 2000). Na maioria dos casos, este subtipo de *stalker,* apresenta uma perturbação psiquiátrica, geralmente de natureza psicótica: erotomania, esquizofrenia ou mania (McEwan & Strand, 2013). O *stalker inapropriado (incompetent stalker),* é aquele que persegue com o objetivo de iniciar uma relação. Este reconhece o desinteresse da vítima e o facto do seu sentimento de afeto não ser correspondido, mas avança na sua conduta com a esperança de mudar essa situação. Normalmente os agressores são indivíduos intelectualmente limitados, com parcas competências sociais. (kamphuis & Emmelkamp, 2000; McEwan & Strand, 2013). Envolve pessoas desconhecidas ou com quem o/a *stalker* mantém contactos ocasionais. Em relação ao *stalker predador*, os comportamentos de perseguição

funcionam como uma fase preparatória da agressão sexual, com o objetivo de recolher informação sobre a potencial vítima. Raramente são avisos intimidatórios, pelo que a vítima tende a desconhecer o perigo. Nestes casos, o/a *stalker* tende a ser um/a desconhecido/a. Este tipo de *stalker* é raro e pode apresentar parafilias. (Whyte et al., 2008; McEwan & Strand, 2013; Matos et al., 2011).

Aspetos psicopatológicos

O fenómeno *stalking* tende a ser subdiagnosticado. Em relação aos *stalkers* ex-parceiros da vítima, estes apresentam sobretudo traços mal-adaptativos de personalidade (Mullen et al, 1999).Vários estudos revelam que o *stalking* encontra-se frequentemente associado a Perturbações de Personalidade do *cluster* B (personalidade narcísica, antisocial e borderline), e em menor grau a personalidades do tipo dependente e paranoide (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; McEwan & Strand, 2013). A maioria da psicopatologia grave está presente em *stalkers* que perseguem vítimas desconhecidas, e não em *stalkers* ex-íntimos das vítimas (McEwan & Strand, 2013). Em casos menos frequentes, o/a *stalker* pode apresentar sintomatologia grave com perda do contacto com a realidade, e pode ser manifestação de perturbação psiquiátrica como psicose (Esquizofrenia e Erotomania) ou de um episódio maníaco (Catanesi et al., 2012; McKenzie & James, 2011). Perturbações psicóticas são mais prevalentes em *stalkers* desconhecidos das vítimas, e estudos revelam uma relação temporal estreita entre o início da psicose e o início dos comportamentos de *stalking* (McEwan & Strand, 2013). A maioria das ideias delirantes são de natureza erotomaníaca ou persecutória, ou enquadradas em Delírios de Ciúme (crença de que o/a companheiro/a é infiel com base em factos com baixo limiar de evidência) (McKenzie & James, 2011). Ao contrário do que poderia ser expectável, a presença de perturbação psicótica no *stalker* não foi considerado um significativo preditor de violência (Farham

et al., 2000). O papel de uma perturbação mental grave parece ser particularmente importante quando se trata de *stalkers* do sexo feminino, comparativamente ao sexo masculino (Catanesi et al., 2012). Em adição a estes diagnósticos, *stalkers* podem também apresentar outras condições comórbidas, nomeadamente abuso e/ou dependência de substâncias e outras perturbações afetivas (Kamphuis & Emmelkamp, 2000). Relativamente à categoria de *stalking* de natureza psicótica, esta revela-se frequentemente refratária às medidas e intervenções legais, pelo que o seu tratamento deverá ser dirigido às crenças delirantes subjacentes, com provável necessidade de medicação antipsicótica e sem benefício ou indicação para iniciar psicoterapia (Kamphuis & Emmelkamp, 2000; McKenzie & James, 2011). Contudo, o grupo mais prevalente de *stalkers*, que corresponde na sua maioria, a casos de *stalkers* rejeitados com traços disfuncionais graves de personalidade poderá beneficiar de intervenções psicoterapêuticas e legais (Kamphuis & Emmelkamp, 2000). Várias teorias foram propostas numa tentativa de encontrar uma explicação para o fenómeno *stalking*. De todas elas, a teoria de vinculação é a que mais emerge como tema comum. Segundo esta teoria explicativa, o *stalking* poderá ser o resultado de estilos de vinculação disfuncionais. Amostras clínico-forenses de *stalkers* revelam que estes têm maior probabilidade de falhar no desenvolvimento de padrões de vinculação seguros na infância, e de apresentar estilos de vinculação inseguros em adultos, que se traduzem numa maior dificuldade em gerir as suas relações interpessoais, apresentando défices na comunicação, baixa autoestima, maior dependência emocional, medo de rejeição e angústia de separação marcada (Kamphuis & Emmelkamp, 2000; MacKenzie et al., 2008). O *stalking* pode ser o resultado de diferentes motivações e constelações psicopatológicas de sintomas. A distinção fenomenológica é importante, uma vez que a minoria de *stalkers,* os quais sofrem de perturbações psicóticas, são considerados

inimputáveis pelos seus atos e deverão ser tratados em enfermarias assistenciais para esse contexto (Kamphuis & Emmelkamp, 2000;McEwan & Strand, 2013). No âmbito da psicopatologia encontrada nas vítimas, surgem quadros clínicos variados que configuram perturbações afetivas, ansiosas (em particular a perturbação de stress pós-traumático) e somatoformes (Van der Aa, S. & Romens, 2006; Dressing et al., 2007). As perturbações psiquiátricas são mais frequentes e significativas em situações de abuso físico ou sexual (Purcell at al., 2005), sendo que a mesma pode persistir após a cessação dos comportamentos *stalking* (Purcell et al., 2001).

Aspetos médico-legais

Até muito recentemente, o *stalking* não era crime, mas havia a necessidade de criar legislação específica para este fenómeno, como já existia em vários países. No passado o que existia em Portugal era unicamente a possibilidade de criminalizar individualmente alguns comportamentos; o *stalking* não era considerado um tipo legal de crime em si mesmo, sendo reconhecido somente quando o comportamento violava uma norma já instituída. Ou seja, só era possível criminalizar atos isolados sem atender ao problema como um todo. Mais recentemente surge um esforço de operacionalizar o conceito do *stalking* de um ponto de vista legal, que visa a sua criminalização. Portugal também tipificou as condutas relacionadas com a perseguição por meio da introdução do artigo 154º -A no Código Penal. Neste sentido, foi introduzido um aditamento ao Código Penal Português com vista à criação do novo tipo legal de crime de "Perseguição" (Artigo 154º - A), tendo este sido integrado no elenco dos crimes contra a liberdade pessoal. A tipificação aprovada atribui ao crime uma natureza semipública, com uma moldura até 3 anos de prisão ou pena de multa. Implica a presença de diferentes elementos estruturais (a conduta, a intenção do ofensor, as consequências implicadas), sendo tipicamente identificado como um padrão de comportamentos

repetidos, intencionais, não desejados pelo(s) alvo(s) e que induz medo nas suas vítimas ou que, em alternativa, é percebido como ameaça- dor ou atemorizador por uma "pessoa razoável". Em bom rigor, as perícias médico-legais apenas deveriam ser solicitadas, quando o Tribunal tem dúvidas, o que acontecerá quando existem evidências no processo de que o stalker apresenta efetivamente patologia psiquiátrica grave, ou quando pela bizarria do seu comportamento existe uma forte suspeição dessa mesma patologia (McKenzie & James, 2011). Todavia, a experiência tem mostrado que muitas das vezes bastará uma ténue suspeita ou a mera solicitação do advogado de uma das partes para que seja suscitada uma alegada dúvida, e assim seja ordenada uma perícia, porventura médico-legalmente desnecessária e que acarretará para além dos custos, uma significa morosidade dos processos. De facto, como já referido previamente, apenas uma minoria dos *stalkers* apresentará um quadro psiquiátrico grave suscetível de destruir a conexão lógica de sentido entre o agente e o facto, de tal modo e grau, que o facto não possa ser compreendido como facto daquele mesmo agente, ou seja, que integre pressupostos médico-legais para inimputabilidade. Desta forma, na grande maioria dos casos não se afigurará necessária a solicitação de uma perícia psiquiátrica nos termos do artigo 159º do Código Processo Penal, ausentes que estão os pressupostos médico-legais de inimputabilidade previstos no artigo 20º do Código Penal. Algo bem diferente, acontece porém relativamente ao construção jurídico de perigosidade, leia-se a repetição de factos típicos semelhantes ou da mesma espécie (no caso o comportamento ameaçador e persecutório), e assim, quanto à perícia sobre a personalidade prevista no artigo 160º do Código de Processo Penal. É que efetivamente, a grande maioria destes indivíduos apresentará senão distúrbios de personalidade - não necessariamente doenças psiquiátricas - pelo menos, traços de personalidade que inexoravelmente conduzirão a uma prognose de risco de violência e assim pressupostos

médico-legais para perigosidade jurídico-criminal. Igualmente poderá ser pedido ao perito que se pronuncie relativamente à melhor gestão dos casos de *stalking*, nomeadamente às medidas que do ponto de vista estritamente médico-psiquiátrico e psicológico poderão estar indicadas, e assim ser esta perícia do artigo 160º do Código de Processo Penal, útil para o juízo referente à " decisão sobre a culpa do agente e a determinação da sanção", adequando-se a pena àquele comportamento e àquela personalidade.

Discussão e Conclusões

Apesar de variações na sua definição, o corpo cientifico atual que debate o tema do *stalking*, permite uma boa base de entendimento e compreensão para a natureza do fenómeno. Existem diferentes vítimas, agressores, motivações e condutas utilizadas. Diferenciar os *stalkers* com base na natureza da sua relação com a vítima poderá ser útil na compreensão das possíveis consequências e riscos inerentes a esses comportamentos. Contudo, esse conhecimento fornece pouca informação acerca da melhor alternativa de manejo e tratamento, uma vez que diferentes *stalkers,* com relações de natureza semelhantes com as vítimas podem assumir motivações distintas. Assim, as considerações sobre a psicopatologia do fenómeno *stalking* são importantes. Na sua esmagadora maioria, tais comportamentos são perpetrados por parceiros/ex-parceiros das vítimas e são enxertados não em patologia propriamente dita, mas antes em perturbações de personalidade, nas quais não surge afetação da responsabilidade criminal. Ainda que, a Perturbação de Personalidade sempre possa ser considerada uma anomalia psíquica, em bom rigor, em termos médico-legais não a poderemos considerar clinicamente grave ou de natureza psicótica (com distorção do sentido da realidade), de forma a prejudicar a capacidade de avaliação e/ou determinação. O *stalking* descreve uma derivação comportamental e não representa uma classificação psiquiátrica per se. A maioria das aborda-

gens psiquiátricas traduzem-se na tentativa de distinguir os *stalkers* com perturbações psicóticas dos *stalkers* com Perturbações de Personalidade. O *stalker* psicótico pode ocorrer em contexto de uma erotomania primária ou delírio erotomaníaco e/ou de ciúme em contexto de esquizofrenia e/ou num episódio maníaco, por exemplo. O *stalking* na população em geral está mais associado a Perturbações de personalidade do cluster B (borderline e narcísico), e em menor extensão aos subtipo dependente, paranoide. Os estudos que propõem relações entre personalidade e funcionamento intrapsíquico dos *stalkers* são sobretudo de natureza psicodinâmica, sublinhando o papel de uma reação narcísica à perda e rejeição. Embora os diagnósticos psiquiátricos estejam bem estabelecidos, existe uma amostra bastante heterogénea quanto as manifestações psiquiátricas que podem estar inerentes ao *stalking*. A maioria da literatura incide na dicotomia *stalker* psicótico *versus* não psicótico. Estas dicotomias são muitas vezes avaliadas separadamente sem muitas vezes se considerar que essas situações se podem sobrepor a outras condições (efeito patoplástico da personalidade de base, comorbilidades, abuso de substâncias) (Catanesi et al., 2012). Deste modo, a distinção fenomenológica é fundamental não apenas no âmbito clínico mas também forense. O Tratamento deverá ser dirigido à sintomatologia inerente daí a importância do diagnóstico diferencial, sendo que, o tratamento dos *stalkers* beneficiará também as vítimas.

Conflitos de Interesse:

Os autores declaram não ter nenhum conflito de interesses relativamente ao presente artigo.

Fontes de Financiamento:

Não existiram fontes externas de financiamento para a realização deste artigo.

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Psychopathological and Medical-legal Aspects of Stalking

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Abstract

Background: *Stalking* may be defined as a typified, persistent and repetitive behavior of harassment and persecution, namely by stealthy approximation, communication, non-consented contact, surveillance and monitoring of a person. Recently, remarkable efforts had been made towards the characterization of its legal concept, in Portugal, which ended in its criminalization. Aims: To revisit the concept of *stalking*, its definition, victim and aggressors' profile, emphasizing the inherent psychopathological considerations, its medico-legal aspects and explore the legal framework of *Stalking* in Portugal. Methods: Non- Systematic Literature Review. Results and Conclusions: The considerations about the psychopathology of the widespread phenomenon of *stalking* are scarce. In the vast majority of cases, disruptive behavior subscribes to clinical pictures of personality disorders whose legal responsibility is intact. In more rare cases, *stalking* behavior is explained by a severe mental illness, namely psychosis. In the latter, situations of non-imputability may arise. Consequently, the phenomenological distinction of these is of paramount importance not only in the clinic but also in the forensic context.

Keywords: *Stalking*, Psychopathology, Forensic Psychiatry, Criminal Responsibility

Psychopathological and Medical-legal Aspects of Stalking

The existing definitions for stalking differ according to the country and legislation in force. More recently it began to be recognized in several areas: scientific, social, legal-legal and medical. Currently, stalking is defined as a typified form of interpersonal violence, consisting of a pattern of persistent, non-consensual, and unwanted harassment and harassment that translates into various forms of approach, communication, contact, surveillance, and Monitoring of a target person so as to terrify and constrain their behavior and free-will (Kamphuis & Emmelkamp, 2000; McEwan & Strand, 2013; Matos et al., 2012; Spitzberg. & Cupach, 2007). Despite the fact that some Portuguese authors use the term "persistent harassment" as a Portuguese translation, and the term "persecution" has been accepted in the legal epigraph of crime, the authors's opinion is that both expressions alone do not represent a satisfactory conceptual translation of the phenomenon, able to cover it in the various aspects, therefore the authors chose to use the original Anglo-Saxon expression (Matos et al., 2012). The difficulty of conceptualizing the phenomenon can be explained by its insidious and heterogeneous nature, since there are different typologies of victims and aggressors, different motivations, and the strategies used by the stalker can take many different forms (Sheridan et al., 2003; McKenzie & James, 2011; Owens, 2015). Stalking behaviors support varying degrees of severity, from more routine and seemingly harmless acts (sending written messages, repeated phone calls, sending gifts, graffiti, notes left in the victim's vehicle, stealth photographs) to more threatening and intimidating actions, Psychological, physical and / or sexual threats and assaults) (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; Tjaden & Thoenness, 1997). Stalking may have a brief or longer duration in time. Most community disciplines focus on the evidence of repetitive and persistent behaviors that evoke in the victim a subjective sense of fear and threat. A characteristic of its own po-

tentiality relates to the duration time, which is an extension in time, tends to scale in frequency and gravity. In some cases, violence may escalate to culminate in the victim's homicide (Ostermeyer et al., 2016). Most definitions underline the evidence of repetitive and persistent behaviors that evoke a subjective sense of fear and threat in the victim. A characteristic of its potential danger relates to the duration of this type of conduct, since, as it protracts over time, it tends to scale in frequency and severity. In some cases, violence may escalate to culminate in the victim's homicide (Ostermeyer et al., 2016). In an international study of a forensic sample that included individuals charged with harassment and threatening crimes, approximately 21 to 25% of forensic stalking cases culminate in significant violence (Harmon et al., 1995). Stalking behavior can also be executed by perpetrators using electronic communication media, such as the Internet, thus constituting a more sophisticated form of persecution: cyber-stalking (Southworth et al., 2007; Drebing et al., 2014). The latter allows aggressors to overcome geographical barriers and work anonymously, making it difficult to locate them. This phenomenon faces several limitations regarding its process of sociocultural and judicial validation. In some countries in Europe, stalking is still not a distinct legal offense, making it difficult to systematically identify and monitor these cases (Kamphuis & Emmelkamp, 2000). Data estimating prevalence and incidence are scarce and come mainly from American studies, where the prevalence rate for lifetime victimization is approximately 12 to 16% in women and 4 to 7% in men (Sheridan et al., 2003; McKenzie & James, 2011). In the national context, data collected through the “Stalking Victimization Inventory” (Matos, Granjeia, Ferreira & Azevedo, 2009), in a study based on a representative sample of the Portuguese population, 19.5% of the participants reported having been stalked at some point in their life. (Matos et al., 2012). More recently, the results of the European Union Agency for Fundamental Rights (FRA, 2014) study, which carried out

the exhaustive collection of data on violence against women in 28 (EU-28) member states, including Portugal, revealed that 18% of women had experienced stalking since the age of 15, and 9 million women in the EU-28 were stalked in the 12 prior to the study. The results of the prevalence and incidence of this phenomenon may be hampered by the inconsistency of the definition and limitation of the concept (Owens, 2015), regarding what behaviors are understood as stalking, what consequences ensure the role of victim, The minimum duration and frequency of behaviors (Sheridan et al., 2003; Whyte et al., 2008). Prevalence rates may still be contaminated by false reports of victimization (Sheridan et al., 2003). Indeed, in the international context, even in countries where the criminalization of stalking has been recognized for several years, the phenomenon prevails underreported (Brady & Nobles, 2015).

Method

Aims

Throughout this article, the authors perform a general analysis of the profile of the victims and aggressors, and aim to expose and debate the most frequent psychopathological considerations, alerting to the importance of the phenomenological distinction and the inseparable medical-legal aspects of this phenomenon.

Material and Procedure

The authors performed a non-systematic review of the literature by consulting the electronic databases MEDLINE / PubMed and other relevant works, such as manuals and documentation to support health professionals. Studies were written in English and Portuguese. The keywords used were: Stalking, psychopathology, Forensic Psychiatry and criminal responsibility.

Results

Victim typologies

Any person can be a victim of stalking at some point in their life, and the victims do not constitute a homogeneous group (Sheridan et al., 2003). However, the victims of stalking are mostly female, and belong to the age group between 18 and 30 years (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; Matos et al.,2011); McEwan & Strand, 2013; Southworth et al., 2007). In a study with a representative sample of the Portuguese population, in about 40% of the cases, the victim knew the aggressor. In 31.6% of the cases, the perpetrators corresponded to partners/ ex-partners of the victim (Matos et al., 2011), a percentage lower than that reported in international studies that point to up to 80% of cases in which there is a current or previous intimate relationship.(Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; Melton, 2007). Frequently, there is a temporal link between the end of the relationship and the beginning of stalking, a phenomenon that is reproduced in both national and international scenarios. Also, previous history of abuse is very common among women victims of persecution, and suffering from domestic violence increases the likelihood of being a victim of stalking (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; Tjaden & Thoenness, 1997). For victims of former partners, the victim is usually female and there is a greater likelihood of stalking behaviors occurring over a longer period of time, more frequently, and with a higher risk of intimate violence (Tjaden & Thoenness, 1997). In fact, the existence of an intimate relationship is considered the most significant predictor of violence (Mullen et al, 1999; Ostermeyer et al., 2016). Other documented predictors of significant violence are: intimate behavior/ threats, substance use, previous history of violence, criminal history, presence of cluster B personality disorder, and suicidal ideation by the stalker (Mullen, 1999; Farham et al., 2000; Ostermeyer et al., 2016; Dressing et

al., 2007). It can also occur among male victims and female offenders or between former same sex partners (Purcell et al., 2001).

Regarding the heterogeneity of the victims, Mullen, Pathé e Purcell (Apud *"Stalking: Psychiatric Perspectives and Practical Approaches"*, 2007), tried to categorize them according to the context in which stalking occurs and the nature of victim's relationship with the stalker. Victims can be classified as: a) known or friends of the stalker (in this case, stalkers dysfunctionally seek to establish an intimate relationship, more often after a casual encounter and generally suffer from poor social skills); b) Victims in the context of professional support relationships which, due to their proximity and regular contact, may present an increased risk of stalking (health professionals, social workers, teachers, among others); In this group, stalking behaviors usually arise after the end of the professional relationship that is perceived as abandonment and rejection; c) Victims in a work context, where *stalking* may involve any individual in the hierarchical pyramid, for the same reasons (employer and subordinates, clients and coworkers); d) Victims by strangers e) Celebrity victims: politicians, television presenters, actors, who are an easy target for stalkers due to their media exposure (Sheridan et al., 2003; Matos et al., 2011). The celebrity victims are often persecuted with the intention of establishing a relationship of intimacy, revenge or obtaining favors (Matos et al., 2011). By definition, stalking behaviors result in feelings of fear and insecurity that are more severe when the perpetrator is male (versus female), unknown (versus known to the victim), whether there are heteroaggressive behaviors (rather then persecution behaviors) and in the presence of longer duration of behavior (versus shorter duration) (Podaná & Imríšková, 2014). There are some cases of "false victims" that correspond to the exchange of roles, in which the stalker accuses the victim of persecuting him, in order to maintain legal contact with her (Matos et al., 2011). False reports of victimization

may be related to secondary gains, or are the result of previous traumatic experiences. Ex-victims may perceive neutral behaviors as stalking, in the context of widespread hypervigilance and mistrust. False victims may also correspond to cases of psychiatric disorders, due to the presence of delusional persecutory ideas and/or hallucinatory activity.

Agressor Typologies

Several taxonomies have been proposed by different authors regarding the typologies of stalkers. These tend to be also characterized according to their psychological characteristics and according to the nature of the abuser-victim relationship (Kamphuis & Emmelkamp, 2000). Regarding the typology of stalker, the majority is male and corresponds to the figure of a former companion of the victim (Spitzberg. & Cupach, 2007; Dressing et al., 2006; Matos et al., 2011). Ex-partners tend to be more violent than the unknown stalkers (Tjaden & Thoenness, 1997). For this reason, most authors agree on the importance of distinguishing cases where there is some kind of previous relationship between the victim and the aggressor, from those where there is no real relationship (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003). Concerning intimate partners, they tend to be more perverse in their *modus operandi*, experts in the art of coercive control, have more criminal past associated with violence, history of drug and / or alcohol use, but rarely present with psychotic symptoms (Sheridan et al., 2003; Logan, 2010; Matos et al., 2011). Several studies suggest a "typical" stalker profile, corresponding to male individuals aged between 35 and 40 years, usually unemployed, with a psychiatric and/or criminal history (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003). It is also common a past of failed relationships (Sheridan et al., 2003). Not all stalkers act alone contrary to the preconceived idea about this mode of action. The term "stalking by proxy" translates the situations in which others are involved in tracking the vic-

tims (Logan, 2010; Matos et al., 2011). Such persons may have recourse to professionals, private investigators, family members or even the new partner. This type of stalking is particularly common among health professionals such as mental health professionals (Mullen et al, 2000). Several classification systems for stalkers were proposed for characterizing the population of perpetrators, identifying predictors of violence risk associated with particular groups, and outlining intervention strategies (Racine & Billick 2014). The classification of Mullen et al. distinguishes 5 subtypes of stalkers, recognized by Portuguese authors (Matos et al., 2011). These subtypes integrate the context in which the behaviors, stalker motivations, psychological characteristics and the nature of previous relationship with the victim occur: the *rejected stalker*, the *resentful stalker*, the *intimacy-seeking stalker*, the *incompetent stalker* and the *predatory stalker* (Sheridan et al., 2003; Whyte et al., 2008; Mullen et al., 2000; Mullen et al, 1999; Matos et al., 2011).

Regarding the *rejected stalker*, the most common type, stalking behaviors typically arise after the ending of an intimate relationship, and the stalker acts with the purpose of obtaining retaliation, driven by the desire for revenge, or possibly by a complex and volatile combination of both motives (Kamphuis & Emmelkamp, 2000; Whyte et al., 2008; McEwan & Strand, 2013; Matos et al., 2011). This type presents itself as the most intrusive and persistent of all stalkers, with a higher risk of becoming violent (Mullen et al, 1999; Catanesi et al., 2012). In psychopathological terms, rarely corresponds to disorders of a psychotic nature, however, it can reveal serious personality disorders related to feelings of ownership, dependence, distrust and narcissism. The *resentful stalker* persecutes the victim driven by the feeling of revenge or validation, after an episode perceived by himself as negative, for example as an injustice or humiliation. (Kamphuis & Emmelkamp, 2000; Whyte et al., 2008; McEwan & Strand, 2013; Matos

et al., 2011). In some cases it may be associated with basic paranoid or narcissistic functioning. The *intimacy-seeker stalker, e*ngages in stalking behaviors in search of an intimate relationship with the victim who believes to be his "true love", driven by the belief of a romanticized and idealized love. Victims usually have no relation to the stalker, e.g. celebrities or subjects occupying a higher social status (kamphuis & Emmelkamp, 2000). In most cases, this stalker subtype presents a psychiatric disorder, usually of a psychotic nature: erotomania, schizophrenia or mania (McEwan & Strand, 2013). The *incompetent stalker,* is the one who pursues the victim in order to initiate a relationship. He recognizes the victim's disinterest and the fact that his feelings of affection are not reciprocated, but he advances in his behavior in the hope of changing this situation. Usually aggressors are intellectually limited individuals with poor social skills. (kamphuis & Emmelkamp, 2000; McEwan & Strand, 2013). This type, envolves unknown people or occasional contacts. Regarding the *predatory stalker*, the persecution behaviors represent a preparatory stage of sexual aggression, aiming to collect information about the potential victim. Rarely are intimidatory warnings, reason why the victim tends to not know the danger. In these cases, the stalker tends to be an stranger/unknown to the victim. This type of stalker is rare and may present paraphilias. (Whyte et al., 2008; McEwan & Strand, 2013; Matos et al., 2011).

Psychopathological aspects

The stalking phenomenon tends to be underdiagnosed. In relation to the stalkers ex-partners of the victim, these present mainly maladaptive traits of personality (Mullen et al, 1999). Several studies have shown that stalking is often associated with Cluster B Personality Disorders (narcissistic, antisocial, and borderline personality), and to a lesser extent personalities of the dependent and paranoid type (Kamphuis & Emmelkamp, 2000; Sheridan et al., 2003; McEwan & Strand, 2013). Most severe

psychopathology is found in stalkers chasing unknown victims, not in ex-intimate stalkers of victims (McEwan & Strand, 2013). Less frequently, the stalker may present severe symptoms with loss of contact with reality, and may be a manifestation of psychiatric disorder such as psychosis (Schizophrenia and Erotomania) or a manic episode (Catanesi et al., 2012; McKenzie & James, 2011). Psychotic disturbances are more prevalent in unknown stalkers of the victims, and studies reveal a close temporal relationship between the onset of psychosis and the onset of stalking behaviors (McEwan & Strand, 2013). Most delusional ideas are either erotomaniac or persecutory, or framed in Delusions of Jealousy (belief that the partner is unfaithful on the basis of facts with a low threshold of evidence) (McKenzie & James, 2011). Contrary to what might be expected, the presence of psychotic disturbance in the stalker was not considered a significant predictor of violence (Farham et al., 2000). The role of a serious mental disorder seems to be particularly important when it comes to female stalkers, compared to males (Catanesi et al., 2012). In addition to these diagnoses, stalkers may also have other comorbid conditions, such as substance abuse and/or dependence and other affective disorders (Kamphuis & Emmelkamp, 2000). With regard to the category of psychotic stalking, it is often refractory to legal measures and interventions, and its treatment should be directed to the underlying delusional beliefs, with a probable need for antipsychotic medication and without benefit or indication to initiate psychotherapy (Kamphuis & Emmelkamp, 2000; McKenzie & James, 2011). However, the most prevalent group of stalkers, which corresponds mostly to cases of *rejected stalkers* with severe dysfunctional personality traits, may benefit from psychotherapeutic and legal interventions (Kamphuis & Emmelkamp, 2000). Several theories have been proposed in an attempt to find an explanation for the stalking phenomenon. Of all of them, the theory of linkage emerges as the most common theme. According to this explanatory

theory, stalking may be the result of dysfunctional linkage styles. Clinical-forensic samples from stalkers reveal that they are more likely to fail to develop safe attachment patterns in childhood, and to exhibit unsafe attachment styles in adults, which translate into greater difficulty in managing their interpersonal relationships, presenting deficits in communication, low self-esteem, increased emotional dependence, fear of rejection, and marked separation distress (Kamphuis & Emmelkamp, 2000; MacKenzie et al., 2008). Stalking may be the result of different motivations and psychopathological symptoms. The phenomenological distinction is important, since the minority of stalkers, who suffer from psychotic disturbances, are considered non-responsible for their actions and should be treated in care wards for this context (Kamphuis & Emmelkamp, 2000;McEwan & Strand, 2013). In the context of the psychopathology found in the victims, several clinical manifestations may appear, namely: affective, anxious (in particular the posttraumatic stress disorder) and somatoform disturbances. (Van der Aa, S. & Romens, 2006; Dressing et al., 2007). Psychiatric disorders are more frequent and significant in situations of physical or sexual abuse (Purcell et al., 2005), and it may persist after cessation of *stalking* behaviors (Purcell et al., 2001).

Medico-legal aspects

Until recently, stalking was not a crime, but there was a urge to create specific legislation for this phenomenon, following the example of other several countries. In the past, what existed in Portugal was only the possibility of criminalize individually some behaviors; Stalking was not considered a legal type of crime in itself. Therefore, it was only possible to criminalize isolated acts without addressing the problem as a whole. More recently, an effort has been made to operationalize the concept of stalking from a legal point of view and criminalize it. Portugal has also typified the conduct related to the persecution through the introduction of Article 154-A in the Penal Code. In this

sense, an amendment to the Portuguese Penal Code was introduced with a view to creating the new legal type of crime of "Persecution" (Article 154-A), which was included in the list of crimes against personal freedom. The approved typification gives the crime a semi-public nature, with up to 3 years of imprisonment. It covers the presence of different structural elements (the conduct, the offender's involvement, the consequences), being typically identified as a pattern of repeated, intentional, unwanted behaviors by the target(s) capable of inducing fear in their victims or, alternatively, is perceived as threatening or frightening by a "reasonable person." Strictly speaking, medico-legal expertise should only be requested when the Court has doubts, which will happen when there is evidence in the process that the stalker actually presents severe psychiatric pathology, or when, due to the bizarre nature of his behavior, there is a strong suspicion of a psychiatric condition (McKenzie & James, 2011). However, experience has revealed that many times it is only necessary a slight suspicion or the mere request of the lawyer of one of the parties to raise an alleged doubt, and thus to order a medico-legal examination, perhaps unnecessary and which could raise the costs, and could mean the slowness of the process. In fact, as mentioned previously, only a minority of stalkers will present a serious psychiatric condition capable of destroying the logical connection of meaning between the agent and the fact, to such a degree, that the fact can not be understood as fact of the same agent, that is, that integrates medical-legal assumptions for non-accountability. Thus, in the great majority of cases, it will not seem necessary to request a psychiatric expertise under Article 159º of the Code of Criminal Procedure, absent that there are medical and legal grounds of non-imputability provided in article 20º of the Criminal Code. Something very different, however, is the repetition of similar typical facts (in this case, the threatening and persecutory behavior), as regards the personality test foreseen in article 160º of the Code of

Criminal Procedure. Indeed, the vast majority of these individuals will exhibit personality disorders - not necessarily psychiatric illnesses - at least personality traits that will inexorably lead to a prognosis of risk of violence and thus medical-legal assumptions for criminal-legal danger. The expert may also be asked to give a ruling on the best management of stalking cases, in particular measures that strictly medical-psychiatric and psychological may be indicated, and this is the skill of article 160º of the Code of Criminal Procedure, useful for the judgment concerning the "decision on the fault of the agent and the determination of the sanction", adjusting the penalty to that behavior and that personality.

Discussion and Conclusions

Despite variations in its definition, the current scientific body that debates the theme of stalking provides a good basis for understanding the nature of the phenomenon. There are different victims, aggressors, motivations and behaviors used. Differentiating stalkers based on the nature of their relationship with the victim may be helpful by understanding the possible consequences and risks inherent in such behaviors. However, this knowledge provides little information about the best management and treatment alternatives, since different stalkers with similar nature relationships with the victims may assume different motivations. Thus, considerations about the psychopathology of the stalking phenomenon are important. In their overwhelming majority, these behaviors are perpetrated by partners/ex-partners of the victims, who don't exhibit proper pathology, but rather personality disorders, in which there criminal responsibility is not affected. Although Personality Disorder can always be considered a psychic anomaly, in good medical and legal terms we can not consider it clinically severe or psychotic (with a distortion of the sense of reality), in a way that impairs the ability to evaluation and/or determination. Stalking describes a behavioral

derivation and does not represent a psychiatric classification. Most psychiatric approaches attempt to distinguish stalkers with psychotic disturbances from stalkers with Personality Disorders. The psychotic stalker may occur in the context of a primary erotomania or erotomaniac delirium and/or jealousy in the context of schizophrenia and/or in a manic episode, for example. Stalking in the general population is more commonly associated with cluster B (borderline and narcissistic) personality disorders, and to a lesser extent, the dependent or paranoid subtype. The studies that propose relationships between personality and psychic functioning of the stalkers are mainly of a psychodynamic nature, underlining the role of a narcissistic reaction to loss and rejection. Although psychiatric diagnoses are well established, there is a fairly heterogeneous sample of psychiatric manifestations that may be inherent in stalking. Most of the literature focuses on the psychotic versus non-psychotic stalker dichotomy. These dichotomies are often evaluated separately without considering that these situations can overlap with other conditions (baseline personality patoplastic effect, comorbidities, substance abuse) (Catanesi et al., 2012). For that reason, the phenomenological distinction is crucial not only in the clinical but also in the forensic fields. The treatment should be directed at the inherent symptomatology, therefore the importance of the differential diagnosis. Finally, the treatment of stalkers will also benefit the victims.

Conflicting Interests:

The authors have declared no competing interests exit.

Funding:

The authors have declared no external funding was received for this study.

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Compulsory outpatient treatment: Descriptive analysis of patients referenced to a specialized consultation in Portugal

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Abstract

Compulsory outpatient treatment (COT) varies widely between regions, and there is insufficient knowledge regarding these patients' characteristics. Cross-sectional analyses of 38 patients referenced to a specialized COT consultation, where patients undergo a standardized evaluation every 2 months with the *Positive and Negative Syndrome Scale* (PANSS), *Personal and Social Performance Scale* (PSP), *Berrios-Markova e Scale to Assess Unawareness in Mental Disorder* (SUMD), *Trails* A and B, *Digit Span (DS)*, and the *Controlled Oral Word Association Test* (COWA). Patients were predominantly male (76.3%), single (78.9%), unemployed or retired (81.5%), with a mean age of 40.7 years and a diagnosis of schizophrenia (87%). Patients had a mean of 6.6 previous hospitalizations (1.6 of which compulsory). They presented moderate symptoms (PANSS total = 57.2) and 63.2% were not in resolution, had low levels of personal and social functioning (PSP = 45.9), and low insight on hetero-evaluation (SUMD = 10.8) and self-report (Berrios-Markova = 12.0). We found significant correlations between symptom levels in all PANSS sub-scales and personal and social functioning. Regarding insight, there was only a significant association between SUMD scores and DS ($p = 0.015$). We found significant correlations between scores on Trail-A and total admission duration ($p = 0.018$) and negative symptoms ($p = 0.002$), and scores on Trail-B correlated significantly with all PANSS subscales. Our patients have overlapping characteristics to those followed in COT in other countries. The knowledge of patients' characteristics is fundamental to support implementation of COT, and for the organization of services and targeted treatment plans.

Keywords: cognitive, functioning, involuntary, outpatient commitment, psychosis

Compulsory outpatient treatment: Descriptive analysis of patients referenced to a specialized consultation in Portugal

After decades of studies and reviews on compulsory outpatient treatment (COT) for people with severe mental disorders, there is yet little agreement about whether it reduces health service use, and/or improves clinical outcome, insight, cognition and social functioning. This controversy has itself become part of the challenge in implementing the practice and developing a broader evidence base for its effectiveness (Geller, 2006).

Supporters of COT advocate that it is less restrictive to treat patients compulsorily in the community than to subject them to repeated hospital admissions (Pinfold, Bindman, Thornicroft, Franklin, & Hatfield, 2001; Swanson & Swartz, 2014), and that it brings stability to their lives (O'Reilly, 2001). Opponents of COT believe it to be too coercive, and fear treatment and support will be replaced by a greater emphasis on control, restraint, and threat (Pinfold et al., 2001; Swanson & Swartz, 2014), arguing that intensive case management or assertive community treatment may be all that is needed (Swartz et al., 1995). COT would also drive people with severe mental illnesses away from services, by interfering with the therapeutic alliance between healthcare professionals and patients (Pinfold et al., 2001), and although there are marked variations between studies, a recent review indicates that COT may contribute to a patient's sense of coercion (Pridham et al., 2015).

The literature on COT shows effectiveness to be mixed, with success being conditioned by effective implementation, availability of intensive community-based services, and court order duration (Swanson & Swartz, 2014). These conclusions are drawn from quasi-experimental analyses of COT's outcomes and result from the presumed gold standard of randomized controlled trials (Petrila, Ridgely, & Borum,

2003). However, randomized trials with this population raise ethical and legal concerns; results of trials involving court mandates to participate in outpatient mental health services will differ depending on locally available services, the community environment in which the trial takes place, financing and social insurance schemes, and the sociodemographic characteristics of the participants (Swanson & Swartz, 2014; Swartz et al., 1999; Burns et al., 2013), not to mention the country's legal assumptions. So as Swanson and Swartz (2014) propose, rather than asking whether COT is effective, it is more appropriate to ask, *"Under what conditions, and for whom, can COT be effective?"*

In Europe, the Oxford Community Treatment Order Evaluation Trial (OCTET) revealed no significant differences in readmissions during the follow-up period, length of time to the first readmission, number of readmissions, total amount of time spent in the hospital, clinical and social functioning) both at 12 months (Burns et al., 2013) and at 36-month follow-up (Burns et al., 2015). However, as Swanson and Swartz (2013) stated, *"OCTET was never designed to answer the fundamental question of whether compulsory treatment can work better than voluntary treatment for people who are eligible"*.

But even though some argue that there is sufficient evidence that COT does not work (Maughan, Molodynski, Rugkåsa, & Burns, 2014; Kisely & Campbell, 2015), others think it does (Swanson & Swartz, 2014; Steadman et al., 2001; Nakhost, Perry, & Frank, 2012; Patel et al., 2013; Preston, Kisely, & Xiao, 2002). To justify widespread implementation of COT, it should be accompanied by systematic local evaluations (Swanson & Swartz, 2014). Therefore, there is a need for better characterization of who are the patients that might benefit the most from COT, in order to better establish who

should be transitioned to this treatment regimen, and also to better organize services and treatment plans.

The aim of the present report is to characterize a sample of Portuguese patients referred to a specialized COT consultation, regarding variables that have been insufficiently studied, namely sociodemographic, symptoms, insight and neurocognition. It is part of the systematic evaluation of patients followed in that specialized consultation.

Methods

The Portuguese Mental Health Law

The Portuguese Mental Health Law (*Law 36/98 of July 24: Mental Health Act*, 1998*)* establishes that a person may be compulsorily detained in an appropriate (official) institution when: 1) suffering from a serious mental disorder that, 2) creates a situation of danger to legally protected rights of relevant value, whether of his/her own or those of others, of a personal or patrimonial nature, and 3) refuses to submit to the necessary medical treatment. Moreover, patients who lack the necessary discernment to evaluate the meaning and implications of consent may be compulsorily detained in cases where the absence of treatment can result in a significant deterioration of their condition. The detention is replaced by compulsory outpatient treatment (COT), whenever such treatment can be performed under conditions of freedom; whenever the stipulated conditions are not met by the patient, this is reported to the court and hospitalization is resumed. A review of the patient's situation is mandatory, independently of whether it is requested, every 2 months while COT is maintained, and signed by two psychiatrists.

Participants, Instruments, and Procedures

In 2014 a specialized consultation was created at CHPL - *Centro Hospitalar Psiquiátrico de Lisboa (Lisbon's Psychiatric Hospitalar Centre)*, in Portugal, to follow patients who were transited from compulsory psychiatric hospitalization to COT. This consultation was undertaken shoulder-to-shoulder by a psychiatrist (SB) and a resident (JMO, GS, or ZG), and was responsible for a geodemographical area of around 815,580 inhabitants[1] (INE, 2012). For the present analysis, data was collected from patients' medical charts and from the standardized protocol applied to all patients (every 2-months), consisting of:

a) *Positive and Negative Syndrome Scale* (PANNS) to assess symptom severity (Kay, Fiszbein, & Opler, 1987);
b) Portuguese version of *Personal and Social Performance* (PSP) Scale to assess personal and social functioning (Morosini, Magliano, Brambilla, Ugolini, & Pioli, 2000; Brissos, Palhavã, Marques, Mexia, Carmo, et al., 2012): The ratings are based on the assessment of patient's functioning in four main areas: 1) socially useful activities; 2) personal and social relationships; 3) self-care; and 4) disturbing and aggressive behaviours, which give rise to a 100-point scale, higher scores representing better functioning.
c) *Scale to Assess Unawareness of Disorder* (SUMD) - shortened version - to evaluate illness insight objectively (Amador et al., 1993): consists of 9 items grouped in two parts, and assesses awareness of mental disorder on several dimensions, using a 5-point Lykert scale, varying from 1 (awareness) to 5 (no awareness). We present scores of the first part only: it assesses current awareness of mental disorder, social consequences of illness, and effects of medication; the sum of these three dimensions consists of the overall illness awareness (range: 3-15); higher scores indicate less insight.

[1] This includes inhabitants more recently followed at two new hospitals (Hospital Beatriz Ângelo and Hospital Vila Franca de Xira), since some patients transitioned to COT were referenced to our specialized consultation instead of being followed in those hospitals, especially when the compulsory admission had taken place at CHPL.

d) Portuguese version of the *Markova and Berrios Insight Scale,* to evaluate subjective illness insight (Marková & Berrios, 1992; Vanelli et al., 2010). Scores vary from 0-30, higher values representing better insight.

e) Neurocognitive tests to briefly assess the following cognitive domains: *processing speed* (Trail Making Test part A); *executive functions* (Trail Making Test part B and Controlled Oral Word Association [COWA] (Animal Naming – also a test of verbal fluency). These are well-established tests having detailed descriptions in standard texts (Strauss, Sherman & Spreen, 2006).

The present analysis contains the retrospective analysis of all patient files from the specialized consultation (n = 38) who were evaluated either at discharge from compulsory admission to COT, or at the first COT consultation (usually within 2 weeks), from March 2014 to October 2015, and represents 43% from the total number of patients transitioned to COT in that period at CHPL.

Patients were diagnosed according to DSM-IV criteria (*Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, 1994), ascertained from personal interview and clinical file consultation. Age of onset of psychiatric symptoms and first psychiatric admission were collected to estimate a proxy measure of duration of untreated psychosis (DUP). Remission status was assessed according to operational criteria developed by the Remission in Schizophrenia Working Group (Andreasen et al., 2005).

Since the present analysis is part of a standardized protocol approved by the Clinical Direction and applied to all patients at the specialized consultation, informed consent was not obtained. Some patients refused to participate in some tests, which were calculated as missing values.

According to the Portuguese Mental Health Law (*Law 36/98 of July 24: Mental Health Act*, 1998*)*, patients can be forced to take medication during COT, and all patients were medicated with long-acting antipsychotics, either in monotherapy or in association.

Statistical analyses

Statistical analyses were conducted using version 22.0 of the SPSS® statistical software package. Descriptive statistics were performed (mean, median, standard deviation and range), and normality distribution of continuous measures was checked with the Kolmogorov-Smirnov test. Correlations between sociodemographic, clinical variables, insight, personal and social functioning scores, as well as cognitive variables, were calculated with Pearson's correlation coefficient. Chi-square test was used to test associations between categorical measures and t-test or ANOVA to compare means between two or more groups, respectively.

Results

Patients were predominantly male (76.3%), single (78.9%), unemployed or retired (81.5%), with a mean age of 40.7 years (range 21-64), and a mean educational level of 9 years (Table 1).

The majority of patients had a diagnosis of schizophrenia (87%), followed by schizoaffective disorder (10.5%) and one patient had a diagnosis of psychosis not otherwise specified.

Patients had been without treatment for a mean of 5.8 years before their first admission, had a mean of 6.6 previous hospitalizations, and a mean of 1.6 previous hospitalizations on a compulsory regimen (Table 1). The admission that motivated COT had a mean duration of 40.3 days (Table 1).

At the time of evaluation, i.e. when transitioned to COT, patients showed moderate symptoms (PANSS total score = 57.2, *SD* = 9.69) and 63.2% were not in resolution (Andreasen et al., 2005) (Table 1). Patients presented low levels of personal and social functioning (PSP total score = 45.9), and low levels of insight on hetero-evaluation (SUMD = 10.8) and self-report (Berrios-Markova = 12.0) (Table 1). Performance on cognitive tests is presented in Table 1.

Relationships between sociodemographic and clinical variables, social functioning, insight and cognitive functioning

We found a significant association between civil status and admission duration, with divorced patients being admitted for longer, and married patients for shorter periods ($F = 3.699$, $p = 0.035$). Moreover, divorced patients show more negative symptoms ($F = 3.926$, $p = 0.029$) and longer times on the Trail-A ($F = 4.538$, $p = 0.019$), whereas married patients show less negative symptoms and shorter times on the Trail-A.

Symptom levels did not correlate significantly with illness duration and number or duration of admissions; however, we found correlations between symptom levels and personal and social functioning, namely in positive ($r = - 0.550$, $p < 0.001$), negative ($r = - 0.522$, $p = 0.001$), general psychopathology ($r = - 0.602$, $p < 0.001$), and PANSS total scores ($r = - 0.669$, $p < 0.001$), indicating that more symptomatic patients have more difficulties in personal and social functioning (Table 2). However, personal and social functioning did not correlate significantly with any other variable, namely illness duration, number and duration of admissions, insight for the disorder and/or cognitive performance (data not shown).

Regarding insight, as expected, there was a significant correlation between scores on auto and hetero-evaluation ($r = - 0.479$, $p = 0.004$). However, there was only a

significant correlation between SUMD scores and DS direct scores (r = - 0.523, p = 0.015).

Regarding cognitive performance, we found significant correlations between scores on Trail-A and total admission duration (r = 0.414, p = 0.018), and negative symptoms (r = 0.532, p = 0.002). Interestingly, performance on Trail-B correlated significantly with symptom levels, namely in positive (r = 0.389, p = 0.045), negative (r = 0.569, p = 0.002), general psychopathology (r = 0.438, p = 0.022), and PANSS total scores (r = 0.537, p = 0.004) (Table 2). Although COWA was only applied to 17 patients, a significant correlation emerged with positive symptoms (r = - 0.519, p = 0.039), but with no other variable.

Discussion

Our main purpose was to characterize a sample of patients referred to a specialized COT consultation, regarding variables that have been insufficiently studied, namely sociodemographic, clinical, insight and neurocognitive.

As previously reported, patients were predominantly male, single, unemployed or retired (Swartz et al., 1999; van Baars, Wierdsma, Hengeveld, & Mulder, 2013; Isobel & Clenaghan, 2016). Their mean age was 40.7 years and their mean educational level was 9 years, as in other studies (Swartz et al., 1999; van Baars et al., 2013; Isobel & Clenaghan, 2016; Craw & Compton, 2006).

Accordingly to previous reports, the majority of patients had a diagnosis of schizophrenia (van Baars et al., 2013; Isobel & Clenaghan, 2016; Craw & Compton, 2006). Swartz et al.'s study (1999) had only 43.4% of patients with schizophrenia, but this was probably due to the randomization nature of the study, where involuntary hospitalized patients were randomly assigned to be released (n = 135) or to continue under COT (n = 129).

We found little information regarding DUP in COT patients. Even though our patients' mean of 5.8 years was only a proxy measure and patients may have had treatment before their first admission, in van Baars et al.'s study (2013), in 18% of patients DUP was estimated at 1 year or more; moreover, most patients had previously been hospitalized and 53% had been previously admitted to a psychiatric hospital. In our sample we found a mean of 6.6 previous admissions, 1.6 on a compulsory regimen. This shows that patients are being transitioned to COT mainly after several admissions; this may explain the profile we found. However, the intention to improve the prognosis of schizophrenia may be limited if we apply it only to patients that have had several admissions/relapses and who, therefore, may have an inherently worse prognosis.

The duration of the admission that motivated COT was much longer than that reported by Craw and Compton (Craw & Compton, 2006), 40.3±11.8 versus 8.4±6.0 days, but lower to that of Chang, Ferreira, Ferreira & Hirata (2013), 49.8±52.9. This may be due to differences in community services' organization, which allow patients to be discharged earlier in some countries such as the USA or the UK.

At the time of evaluation patients showed moderate symptoms (PANSS total = 57.2) and 63.2% were neither in resolution nor in remission (Andreasen et al., 2005). This is also similar to previous reports (van Baars et al., 2013; Craw & Compton, 2006; Rugkåsa et al., 2015), since it is common for patients to be discharged with active symptoms. This could be due to the fact that nowadays admissions are required to be as short as possible, but also to the fact that if a patient is discharged to COT, he/she will have to present for consultations and/or treatment administration, or otherwise the admission will resume.

Personal and social functioning levels were low, as previously reported (van Baars et al., 2013; Rugkåsa et al., 2015). This may be due to the fact that patients were

coming out of a recent admission, and still symptomatic. Interestingly, personal and social functioning was highly associated with symptom level, and therefore, it may be expected that symptom improvement with compulsory treatment, will lead to improved functioning. Supporting this, in the past, COT has been shown to improve social functioning and quality of life (van Baars et al., 2013), and after 12 months on COT more patients became employed (Rugkåsa et al., 2015).

Low insight is common in schizophrenia, being a common reason for compulsory admission and/or transition to COT. On the other hand, insight is an important predictor of long-term outcome and may be useful in the early identification of poor responders to treatment (van Baars et al., 2013). In our sample, patients presented low levels of insight on both auto- and hetero-evaluation, and these were significantly correlated.

Improvement in insight in COT patients is associated with improved social functioning, independent from symptoms (van Baars et al., 2013). Therefore, patients could benefit from therapies that aim to enhance illness insight. On the other hand, better illness insight could result in worrying about social relationships, living situation, health and finances, and the negative association of insight scores with self-report quality of life should direct our attention to interventions aimed at social support (van Baars et al., 2013). Finally, improvement in insight might not justify COT maintenance; however, we have no knowledge of follow-up reports on the outcomes of these patients after transition to voluntary regimen. Nevertheless, long-term insight in psychosis seems to be, to some extent, determined from first presentation, showing trait-like properties, and a subgroup of "lacking insight" patients, characterized by a diagnosis of schizophrenia that will remain insightless 3 years after their first episode (Ayesa-Arriola et al., 2014).

Regarding cognitive function, there is a lack of studies on these variables in patients transitioned to COT. Although we did not have a control group, the scores obtained by our patients are below the population norms (Strauss et al., 2006). Moreover, more symptomatic patients perform worse on measures of executive functions, even though correlation tests cannot prove causality, or that causality is in that direction.

This is an area of much needed research, since cognitive function may improve along with symptomatic improvement, and especially with the lack of relapses that COT aims to attain. Moreover, the capacity to consent to treatment, and the need to be transitioned to COT, may also depend on the patient's cognitive function. In our sample, we found that performance on a test of executive functioning (Trail-B) was highly associated to symptomatology, leading us to think that improvement in symptoms might also improve, even if slightly, some cognitive functioning. Interestingly, we did not find an association between scores on this test, and scores on either insight scale, as well as on personal and social functioning. This leads us to think that symptomatic improvement may be the most important factor, since it may cause subsequent improvement in insight and cognitive functioning.

In Portugal there is a lack of data regarding this treatment regimen, and numbers are quite heterogeneous from institution to institution. At CHPL during the period in analysis there were 628 compulsory admissions, but only 88 (14%) patients were transitioned to COT (data not published), as compared to Hospital Magalhães Lemos in the north of Portugal, where in 2002, 70% of compulsorily admitted patients were transitioned to this treatment regimen (Almeida et al., 2008). Although attempts have been made to standardize rules and instruments (Priebe, Watts, Chase, & Matanov, 2005; Fiorillo et al., 2011), only limited data are available on procedures for

compulsory treatment of mentally ill patients in Europe (Quirk, Lelliott, Audini, & Buston, 2003); thus, there is a need to find an international consensus on clinical conditions and procedures regulating it (Kallert, 2008; Fiorillo et al., 2011). In that sense, our group is developing a Checklist to aid the clinician in the decision for involuntary treatment regimen (Brissos et al., in press).

We compared our results with those of other countries, which have different legislations for COT. Variations in legislation, health service structures, and financing clearly influence practice (O'Reilly, Dawson, & Burns, 2012). Nevertheless, remarkable consistency in the characteristics of patients on COT across jurisdictions in very different cultural and geographic settings have been noted (Churchill, Owen, Singh, & Hotopf, 2007), as was the case with our patients. This is interesting since COT use varies widely across countries and jurisdictions with the rates varying from 5 per 100,000 in Canada, to 98.8 per 100,000 in the Australian state of Victoria (O' Reilly, Keegan, & Elias, 2000).

Although our sample is small and from a single centre, it represents 43% of patients transitioned to COT in that period at our hospital, which is responsible for the psychiatric treatment of almost 10% of the country's adult population.

Unfortunately we did not collect systematic information on substance use, personality disorder, aggression and/or detentions or convictions to be able to compare our sample to that of other studies. These are all important variables that should be systematically assessed in the decision to transition a patient from involuntary to voluntary treatment, or instead, to COT. In that sense, our group has developed a Checklist for this effect (Brissos et al, in press). Moreover, DUP was calculated by a proxy measure and not with a specific instrument. Lack of a control group is a well acknowledged limitation of our study. Furthermore, the psychiatrists who administered

the scales and tests were not blinded to patients' symptomatic and functioning state. However, our findings are innovative since they report on patients rarely included in randomized trials, and on rarely studied variables in naturalistically treated patients, such as insight and cognition, which may be of utmost importance for the transition and maintenance of COT.

Conclusions

The present analysis demonstrated that our sample of patients referenced to COT has overlapping characteristics to patients followed in similar regimens in other countries, namely regarding sociodemographic, clinical, functioning and insight scores. Cognitive function is rarely evaluated in these patients, and it may be important regarding capacity to consent to treatment maintenance, as determined by the law.

If COT is to be maintained in our legal system, the knowledge of patients' characteristics is fundamental to support it, since it may be more adequate for patients with some specific characteristics, some of which are already specified in our law, but that are not systematically evaluated, such as insight. This will allow services to better organize adequate and targeted treatment plans, which should be systematically evaluated to support their existence.

Declaração de potenciais conflitos de interesse:

S.B. foi Medical Affairs Manager para a Janssen de 2010 a 2013. Nos últimos 3 anos recebeu honorários por palestras da Janssen e da Lundbeck. Os restantes autores declaram não ter conflitos de interesse.

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Sexual Violence against Children and Adolescents: A Developmental Victimology

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Abstract

In recent decades, there has been an increase in the number of studies on sexual violence against children and adolescents, however, this was the last form of abuse to be studied. This article presents some results from these studies, in particular, concepts, epidemiology, and consequences. We also propose a reflection on the confusion between sexual assault and pedophilia, concluding that there is a consensus among the scientific community that not all sexual perpetrators of children and adolescents are pedophiles and not all pedophiles are sexual perpetrators. We conclude with some reflections on the new horizons of research and the status professionals are giving to violence against children and adolescents, by analyzing the proposal by Finkelhor (2007) on *Developmental Victimology* as a branch of victimology that focuses on juvenile victimization throughout the life cycle.

Keywords: child sexual abuse, developmental victimology, juvenile victimization

Sexual Violence against Children and Adolescents: A Developmental Victimology

Of all forms of juvenile victimization, sexual victimization was the last to catch the interest of the scientific community. Additionally, in almost all countries, the public debate was driven by the emergence of large-scale judicial cases. In Portugal, the academic debate on child and adolescent sexual victimization is recent. Nonetheless, some studies conducted in recent years reveal a growing scientific interest in the issue.

In fact, the broad public debate in our country was triggered by what became known as the "Casa Pia Case". We must mention the importance of this episode, initiated in 2002, towards the visibility that society began to give to victims and the entire phenomenon of sexual victimization of children and adolescents in Portugal. Such a reaction caused intense social debate about the characteristics and explanatory models of victims and perpetrators, abuse itself, and social reaction. On the other hand, it forced a legal debate, which turned out to be prolific in ideas and suggestions, and whose results were reflected in changes and improvements to some laws, the creation of new laws, and in the increase of sentences for sexual crimes already contemplated in the penal code.

As expected, this issue, by involving childhood, sexuality, and violence, provoked strong emotional reactions in individuals and, in an attempt to fill conceptual gaps, generated myths and misconceptions.

Thus, with the unfolding of the Casa Pia trial, we witnessed the emergence of other erroneous beliefs about sexual violence against children and adolescents, but, fortunately, we also saw an increase of knowledge and the replacement of myths for correct information. For example, society began to reflect on the difference between pedophilia and sexual assault, and it was confronted with reliable information from representatives of credible institutions on a number of other issues. These include the

high frequency, the victimization of boys, the severity of the consequences resulting from sexual violence and, at the same time, there was an exponential increase in reports of this crime and other crimes against children. In addition, and very importantly, the Portuguese society understood the ubiquitous nature of sexual violence against minors, in other words, there was a decrease in erroneous ideas that this crime is related to typified criminal agents against easily identifiable targets, to socially disadvantaged families, to girls, among others.

It was observed that the debate was eager for clarification, which is natural when our conceptual schemas are broken: how is it possible that in a place created to shelter suffering individuals, a greater suffering was caused?

This event, the Casa Pia case, which lasted 8 years, carried the task of denouncing a barbarity that society as a whole refused to see (Branco, 1999).

One tries to identify monsters. The figures of perpetrator and victim are interchangeable and the public image of the perpetrator is confused with their private image: good person cannot sexually abuse a child! This conviction, shattered during this social movement born with the Casa Pia case, was nurtured by social constructs over decades and these were scientifically sustained by positivist theorists of victimology, who argue that the victim is, in some measure, responsible for their own victimization (Neves & Fávero, 2010).

Delimitation of Concepts

The first confusion that is observed when talking about sexual violence against minors is associated with terminology: sexual abuse of minors is not the same as pedophilia. So: What is it? What are we actually talking about when we talk about sexual violence against minors?

The proper terminology to use in order to classify a person who sexually assaults children and adolescents and, thus, the difference (or similarities) between sexual perpetrator and pedophile are not simple issues.

And, while public opinion and media classified Marc Dutroux and his accomplices as pedophiles, the acts committed by them (kidnapping, physical abuse, neglect of six girls between eight and 19 years of age, causing the death of four of them) are closer to sadistic behavior.

Since it is not the purpose of this article to broaden the debate on pedophilia, nor to provide a proposal to resolve the controversies that emerged over the last years with the revision of the DSM, we must clarify some terminological controversies.

The definition of pedophilia is controversial and its diagnosis is difficult to conduct. However, the consensus among the scientific community is that not all sexual perpetrators of children are pedophiles, in the same way that not all pedophiles sexually assault children and adolescents (Seto, 2008, 2009).

However, some researchers have presented a proposal, no less controversial (e.g.. Blanchard, 2011; Blanchard et al., 2009), for the replacement, in the DSM-5 (APA), published in 2013, of the terminology pedophilia for the term pedohebephilia, resulting from the union of pedophilia (sexual attraction towards pre-adolescents) with hebephilia (sexual attraction towards pubescents). Blanchard (2011, 2013), moderator of the Sub-group for the Discussion of Paraphilias of the DSM-V claims that, in the DSM-IV-TR, pedophilia is referred to as a sexual interest in pre-adolescents only, and his proposal to broaden to pedohebephilia would then include sexual attraction of adults towards pubescents, that is, early adolescents. The author indicates four reasons for the proposal (Krueger & Kaplan, 2012): a) hebephilia and pedophilia are similar, with both involving sexual attraction towards immature individuals; b) several men (and he

specifically refers to this gender) do not differentiate between pre-pubescents and pubescents; c) many people who sexually assault pubescents are already being diagnosed as pedophiles anyway; d) the author defends that this modification would serve to harmonize the DSM with the definition of pedophilia of the ICD, which is the sexual preference for children, boys or girls, or both, generally pre-pubescent or initiating puberty.

This researcher has argued that the framework given to pedophilia has been systematically criticized in various works as being unsatisfactory, for logical or conceptual reasons. Also, because studies on pedophilia, whose reference parameters are those presented in the DSM-V (which maintained the version of the DSM- IV-TR) have presented ambiguous results (Blanchard, 2011).

In his most recent work, Blanchard (2013) reaffirms his position and criticizes the decision of the APA Board of Trustees for the DSM-V to maintain the definition of pedophilia that was in the DSM- IV-TR.

Given that, throughout this article, we will address issues that refer to both pedophilia and sexual assault, we will adopt the concept of sexual violence against children developed by the National Center of Child Abuse and Neglect (NCCAN, 1978), which has been widely reported in national and international studies. Nonetheless, this definition was expanded in another study (Fávero, 2003) to include adolescents and specify the behaviors present in sexual violence. In addition, there has been advocacy for the use of sexual violence instead of sexual abuse. Therefore, when we refer to sexual violence against children and adolescents, we are speaking of sexual contact and interactions between a child or adolescent and an adult, when the latter (perpetrator) uses the victim to sexually stimulate themselves, the victim, or stimulate another person. Sexual violence can also be committed by a person under 18 years of

age, when this person is significantly more mature than the victim or when they are in a position of power and control over the victim.

For a better understanding of this concept, we clarify that "An adult person" in Portugal are individuals over 18 years of age; "Minor under eighteen, significantly more mature than the child", means that, by being older, they must have a more advanced physical, sexual and emotional development than the victim; "Same age but being in a position of power and control over the victim" refers to the asymmetry of power between peers.

Sexual behaviors include: a) physical contact (anal, vaginal, or oral sex; insertion of fingers or objects in the vagina or anus; caresses that include touching the perpetrator's genitals or the minor's genitals; forcing the minor to masturbate them; forcing sexual contact with animals); b) non-physical contact (proposals for sexual activity, exhibitionism); c) sexual exploitation (production of pornography, child prostitution, forcing the minor to witness the sexual activity of other people).

The relationship between perpetrator and victim is characterized by being coercive and asymmetrical, two fundamental factors in the genesis of sexual victimization towards minors. The asymmetry is based on the difference in age, in vulnerability, and the dependence of the child, which prevents them from freely deciding their participation in the sexual interaction.

On the other hand, children and adolescents possess experiences, maturity and objectives that are very different from those of adults (Fávero, 2003), thus, the motivations of the assault do not matter.

Therefore: any child or adolescent who has sexual contact with an adult is a victim of sexual violence!

Regardless of psychological nuances, tenuous borders among juvenile sexual games, among others, sexual violence, in the Portuguese Penal Code, (Chapter V, Section I) is a crime against sexual self-determination (Lopes, 2008). And what characterizes the lack of sexual self-determination is the a) absence of *consent* (not knowing what the purpose is; not knowing whether what is being proposed is appropriate or not; not being able to choose freely in fear of the consequences; not knowing the potential consequences); b) absence of *equality* (differences in size, age, cognitive ability, physical strength; differences in status and roles; differences in persuasion and influence); *coercion* (emotional manipulation, bribes, threats of loss of affection or rights, intimidation, threats of physical assault, threats against other figures of affection for the child, physical coercion and violence).

Regarding the types of sexual violence, Watson and Halford (2010) and Finkelhor (1999) classify it according to the type of relationship between the perpetrator and the victim: a) intrafamilial sexual violence – which usually involves fathers or step-fathers, older brothers or uncles. Since it tends to extend over time and jeopardizes the bond between the child or adolescent and their main source of support, which is family, intrafamilial abuse presents itself as the most severe type of abuse. Therefore, compared to the other categories, family abuse is the one that is associated with a greater risk of developing difficulties in relationships in adult life. On the other hand, relationships with the remaining members (for example, siblings) are also threatened. Furthermore, there is a greater tendency for victims to be female; b) abuse perpetrated by caregivers who are not part of the family – which includes, for example, teachers, coaches, educators, priests; c) abuse perpetrated by minors under 18 years of age – refers to the victimization of pre-adolescent siblings. On the other hand, there may also occur victimization of children of the same age, who are also usually victims of sexual

violence and repeat the behavior; d) sexual violence perpetrated by women – it involves, for example, very isolated mothers and adolescents coerced to obtain sexual experience; and e) sexual exploitation– the children or adolescents are used as prostitutes and for pornographic production purposes.

The concern of the European Community with this crime and child pornography has led the European Parliament and the Council of the European Union to adopt Directive 2011/92/EU of the European Parliament and of the Council of 13 December of 2011, regarding the fight against sexual violence and sexual exploitation of children and child pornography, replacing the Framework Decision 2004/68/JAI of the Council (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:335:0001:0014:PT:PDF).

Epidemiology

Sexual Violence against Children and Adolescents as a Secret Phenomenon. According to Hébert, Tourigny, Cyr, McDuff, and Joly (2009), victims of sexual violence more easily disclose their experience of victimization when the perpetrator is not a family member. Considering that 85% of female victims and 89% of male victims were assaulted by acquaintances or relatives, it is understood why disclosure and reporting are rare.

In research on the frequency of sexual victimization, of retrospective nature, it is found that most victims did not disclose the experience, but among the disclosed assaults, only a small fraction were reported (Fávero, 1999; Finkelhor,1994; Héber et al., 2009).

On the other hand, many families choose to omit that their child was a victim of sexual violence as a way to protect the child from secondary victimization, the one that results from legal or professional intervention when the sexual violence is reported.

There is also a smaller probability of boys reporting the situation (for example, due to the stigma of homosexuality) or even of it being detected (Finkelhor, 1999a) when the victim is a boy. Moreover, the time the child or adolescent takes to report the sexual violence is related to: fear of the negative effects of reporting, the age of the victim, the type of abuse, that is, if it is intrafamilial or extrafamilial (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003), the affective ambivalence towards the perpetrator, the rewards and insecurity (Barbosa, 2011). In fact, it appears that, in most cases, there is a worsening of the negative impact of the situation after its disclosure (Antunes, 2010).

Alternatively, it may also be that there are less means available for boys and girls to use in order to report sexual violence, given that they are not always knowledgeable on how to file a report to the authorities, or there is no one they trust to whom they can disclose the situation (Cuevas et al., 2010).

The hidden figures of sexual victimization, thus, place this type of crime among those whose incidence is less known.

In the approach to victimization, the victim of a sexual crime is the one that best illustrates the motto of Elias (1986, 1993) when he stated that criminal law recognizes some victimizations but not others and, thus, creates a social reality and official reality of victimization. We would add: the sexual victimization of children and adolescents creates a third reality, which is professional reality.

Many experiences of sexual violence remain confined to private clinics or even offices of official institutions which, for various reasons, to not make the complaint reach the courts. Although it is a public crime, there are professionals who resign from their duty to report or signal sexual violence against children or adolescents. As for the

mental health professionals, their most used argument for not following through with a complaint is that it may harm the therapeutic and/or professional relationship.

Other professionals ignore the signs, so that they do not have to take responsibilities in the complaint and judicial process.

Therefore, the known reality is only the tip of the iceberg, or according to the metaphor by José Costa Santos (1998), it is a "hidden cat with its tail peeking out".

It has been argued, in other instances (Fávero, 2003; 2012) that breaking silence has a high therapeutic value for the victims. The disclosure of the secret, followed by a correct course of action by the institutions called to intervene, is liberating. Most victims claim to have been "reborn" after the disclosure, for it frees them from a secret, reaffirms their identity, it "dis-encloses" them from a self-imposed and hetero-imposed prison, it undoes the wrong ideas that the victim has built about the experience and, especially, it allows them to see the situation also treated as a "police case", which it is in reality.

Data on the prevalence, which refers to the proportion of cases in a certain population (Fávero, 2003), from studies with representative or stratified samples, allow us to conclude that between 10 and 25% of women and 7 and 15% of men were victims of juvenile sexual violence (Finkelhor, 1994; Finkelhor, 1999b; Pereda, Guilera, Forns, & Gómez-Benito, 2009).

In Portugal, the results from studies conducted until 2008 are close to the lower percentages. Data from a national study (Fávero, 2003) showed that 6.7% of the sample has been victims of sexual violence during childhood or adolescence (9.9% women and 3.7% men). Ana Nunes de Almeida (1998) concluded that 13.5% of the total cases of abuse reported by hospitals were cases of sexual violence in childhood and/or adolescence; Jenni Canha (2000) found a percentage of 14.0% of victims of this type of

sexual violence among cases of abuse signaled in hospital context; Bárbara Figueiredo (2005) found 2.6% and Tânia Loureiro, more recently (Loureiro, 2008), found a prevalence of 6.1%.

Furthermore, statistics presented by the Portuguese Victim Support Association regarding the year of 2011 show that 24.5% of sexual crimes refer to sexual violence against children under 14 years of age (APAV, 2012).

Characteristics of the victims

Despite the importance of sexual victimization of boys, studies indicate that most victims are girls data (e.g., Fávero, 2003; Finkelhor, 1994), at the rate of 1.5 girls for each boy. As for the perpetrators, both boys and girls are mostly assaulted by men.

Regarding the typical age for the occurrence of the sexual violence, it is between 7 and 13 years of age (Finkelhor, 1999a). Other authors indicate 10 years of age for girls and 9 years of age for boys (Aboul-Hagag & Hamed, 2012). However, approximately 20% of the situations involve children younger than the mentioned ages (Finkelhor, 1999a), and they are regularly victimized within the family context (Taveira, 2007). Serafim, Saffi, Achá, and Barros (2011) reinforce this idea, situating the age of greater propensity for violence between 7 and 10 years (48.5%) for girls and 3 and 6 years (54.6%) for boys. On the other hand, it can be added that the victimization that begins at an early age tends to be continuous (Finkelhor, 2007).

Although studies indicate that 65.0% of abuse is extrafamilial and 36.0% is perpetrated by members of the family (Taveira, 2007), most perpetrators are close to the victim: parental figures (38.0%), members of the extended family or acquaintances of the victim (17.7%) (Fávero, 2003; López et al., 1995; May-Chahl & Cawson, 2005).

Moreover, it can also be said that when sexual violence against children is perpetrated by adults, these are generally fathers or step-fathers (Serafim, et al., 2011;

Pombo, 2011). Similarly, when women are the offenders, typically they are also acquaintances or relatives of the minor (Tsopelas, Tsetsou, Ntounas, & Douzenis, 2012).

Consequences of the Sexual Victimization of Children and Adolescents

Sexual violence causes physical and psychological consequences (Hornor, 2002; Rosa, 2007), as well as sexual consequences, with the family environment often being the context for this type of violence (Rosa, 2007).

In addition, Margolin and Gordis (2000, as cited in Finkelhor, 2007) add that victimization may interfere with the mental health of the adolescent, the development of their personality, as well as their academic performance, and it may also be associated with delinquent and antisocial behavior. Madu and Peltzer (2001) gave child sexual abuse a connotation of a violent crime against humanity, given its physical and psychological scars.

Extrafamilial sexual abuse seems more violent, in the sense that often the perpetrators resort to physical violence (Taveira, 2007). However, although physical violence is less evident than psychological violence in the intrafamilial environment (Magalhães et al., 2009), the effects of juvenile sexual violence within the family are the most severe (Taveira, 2007; Tavkar & Hansen, 2011), as mentioned above. In addition, it has been demonstrated that a previous experience of sexual violence combined with reduced levels of support, academic commitment, expectations and caregivers with low education levels resulted in lower levels of resilience or in higher levels of global behavioral difficulties (Williams & Nelson-Gardell, 2012). Hornor (2010) adds that, if there is no knowledge of the sexual violence through alerting or reporting to the authorities, and the child has not received treatment, this may lead to severe consequences.

Since the physical signs of violence are often hard to identify, they should not constitute the sole indicators of this event. Furthermore, roughly 90% of children or adolescents do not exhibit physical damage (Modelli, Galvão, & Pratesi, 2012).

Therefore, when a child or adolescent exhibits, for example, suicidal ideation, substance abuse, depression, Post-traumatic Stress Disorder (Hornor, 2010), anxiety, distress, sleep disorders, fears, or phobias (Barbosa, 2011), the hypothesis of sexual violence should be analyzed (Hornor, 2010).

Typically, in an initial phase, at least some victims of sexual violence in childhood or adolescence display symptoms, such as anxiety, aggressiveness, anger, fear, inappropriate sexual behavior (Easton, Coohey, O'leary, Zhang, & Hua, 2011; Fávero, 2003), shame/stigma, guilt (Antunes, 2010; Serafim et al., 2011), and insecurity (Serafim et al., 2011).

Nevertheless, there are also victims who manifest few or even no symptoms (Finkelhor, 1990). Ahmad and Nasir (2010) mention three groups of reactions that victims of sexual violence in childhood and adolescence manifested during the interviews: stability (demonstrating ability to report their experience), absence of pain (exhibiting shame and disappointment), and sadness (displaying resistance to cooperate, with a rigid facial expression, complaining, crying, not speaking and crestfallen).

In 1986, when conducting the first studies on this issue, Briere and Runtz argued the existence of an association between sexual violence against children and adolescents and suicide attempts in childhood or adolescence. From their study, they reported that 55.0% of individuals who experienced this type of violence attempted suicide at least once. A recent study confirms this relationship, demonstrating that an experience of sexual violence in childhood and/or adolescence led 63.2% of the victims to develop suicidal ideation, while 24.5% indeed attempted suicide. However, these high rates were

associated with certain conditions, such as the sexual violence having been perpetrated by a family member, the use of more severe violence, the duration of the abuse, among others (Soylua & Alpaslan, 2013). Nevertheless, there are various protective factors (namely, relationship with family), which reduce the possibility of suicide (Eisenberg, Ackard, & Resnick, 2007).

Removing the victim from their own home (when the abuse is perpetrated by a close relative or neighbor), which may initially be seen as negative, is considered by Phasha (2010) as beneficial for the recovery from the negative consequences of this abuse, since there is a separation from the perpetrator and/or the location where the abuse took place. In addition, the victims receive professional help and the perception of security increases. However, these alternatives should not be continued and the non-abusive relatives should be encouraged to visit the minor regularly.

On the other hand, regarding the long-term consequences, the symptoms typically observed are general health problems (Sachs-Ericsson, Kendall-Tackett, & Hernandez, 2007; Irish, Kobayashi, & Delahanty, 2010), depression, anxiety, (Finkelhor, 1990; Hall & Hall, 2011), low self-esteem, self-destructive behavior, difficulty to trust others, substance abuse, feelings of isolation and stigma, sexual inadequacy, revictimization (Finkelhor, 1990), shame, guilt, somatic and eating disorders (Hall & Hall, 2011), perpetration of violence, risky sexual behavior, alcohol and/or drug abuse, smoking habits (World Health Organization, 2010), cardiopulmonary symptoms, pain, gastrointestinal problems, gynecological problems (Irish, et al., 2010), and obesity (Bentley & Widom, 2009; Irish et al., 2010; World Health Organization, 2010), and in the study by Finkelhor, Hotaling, Lewis, and Smith (1989 as cited in Finkelhor, 1990) the victims also manifested lower levels of sexual satisfaction, religiosity, and more conjugal separations. Moreover, other authors

(Weierich & Nock, 2008) argue the existence of a relationship between sexual violence during childhood and self-harm during adolescence.

Maniglio (2009) found that individuals who survive sexual violence during childhood are likely to develop a series of health problems, such as Post-traumatic Stress Disorder, sexual dysfunction, among others. For example, some problems, such as risky sexual behavior or eating disorders, show a weaker relationship with sexual violence against children and adolescents than, for example, Post-traumatic Stress Disorder. Other researchers (Cantón-Cortés & Cantón, 2010) corroborate the hypothesis of Post-traumatic Stress Disorder, adding that it may be of higher or lower intensity according to the coping strategy applied. On the other hand, since the situation of sexual violence may also influence individuals' coping strategies, the particularities of the abuse will also have an effect on the role they will play. However, sexual victimization should not be particularized to psychopathology, but rather considered as a generalized risk condition (for example, leading to revictimization). The psychological effects resulting from the victimization of children and adolescents may be factors for future victimization (Cuevas, Finkelhor, Clifford, Ormrod, & Turner, 2010). This assumption is strengthened by other authors (Barnes, Noll, Putnam, & Trickett, 2009; Swartout, Swartout, & White, 2011; Noll & Grych, 2011), who claim that there is a relationship between being a victim of sexual violence in childhood and an increased risk of later being sexually re-victimized. Specifically, distress is highlighted as a predictor of this revictimization, although there are external factors that may have greater prominence for this risk. Sexual violence and witnessed violence are highlighted as the experiences in which these external factors may have a greater impact on future victimization than the subsequent psychological consequences (Cuevas et al., 2010).

Regarding the consequences on a sexual level, studies do not coincide. Lalor and McElvaney (2010) found that victims of sexual violence tend to, at a later stage, have several sexual partners, be sexually assaulted, as mentioned previously, and to become pregnant during adolescence. In contrast, Loureiro and Machado (2010) found no significant differences between abused and non-abused individuals regarding amount of sexual partners, as well as promiscuity (for example, sex without commitment). However, the authors hypothesize that this may be due to the resilience of the participants, since most were cases involving non-relatives, mild to moderate severity and of rare or sporadic frequency, reinforcing the idea that sexual abuse that involves penetration and/or force is related to more risk behavior as adults, such as number of partners throughout life, compared to participants in which the abuse did not involve penetration and/or force and compared to those who were not sexually abused (Senn, Carey, Vanable, Coury-Doniger, & Urban, 2007).

Feiring, Simon, and Cleland (2009) claim that the experience of greater obstacles in sexual relationships is explained by stigma (self-blame and shame) and by internalization symptoms (depressive symptoms and Post-traumatic Stress Disorder). In addition, internalization symptoms are also predictors of intimate partner violence.

With regards to sexual violence against boys, there has been great advance in the number of studies conducted since 1986 (Finkelhor, 1990). Nonetheless, throughout our research, it was possible to verify that, despite this, the number of studies found is still small. The first studies on this issue show that, compared to girls, sexual violence against boys tends to not be perpetrated by family members. In turn, it tends to entail the stigma of homosexuality. However, the short-term and long-term effects are visible in both boys and girls and, furthermore, those consequences are similar in both sexes (Conte, Berliner, & Schuerman, 1986; Finkelhor, 1990; Gomes-Schwartz, Horowitz, &

Cardarelli, 1990; Tufts, 1984 as cited in Finkelhor, 1990). In an immediate evaluation of the abuse, the same type of symptoms are manifested: sleeping problems, fears, and distraction (Finkelhor, 1990). In a study by Tong, Oates, and McDowell (1987 as cited in Finkelhor, 1990), the evaluation conducted by parents and teachers regarding the symptoms of the minor shows lower number of symptoms in boys. However, with respect to the evaluation conducted by children or adolescents themselves, boys do not tend to be less somatic than girls. Regarding the differences between the sexes, the most cited ones refer to internalization and externalization, where the former is generally more observed in girls (Conte et al., 1986 as cited in Finkelhor, 1990) and the latter is more observed in boys (Gomes-Schwartz et al., 1990; Tufts, 1984 as cited in Finkelhor, 1990). In contrast, a more recent study indicates that the greater tendency to internalize belongs to males (Coohey, 2010), opening a research avenue to further study this issue with clinical samples.

Recent analyses indicate that, much like in the case of women, the impact of sexual violence during childhood and/or adolescence in males seems to have several consequences in terms of sexuality, such as the number of partners and unprotected sexual relations (Homma, Wang, Saewyc, & Kishor, 2012).

Nevertheless, it should be noted that the consequences described throughout this article are not ubiquitous to all victims and, thus, the specific needs of each victims should be taken into account (Hall & Hall, 2011).

New Perspectives on the Sexual Victimization of Children and Adolescents

If we accept that Victimology, as the general field for study of victims, is reaching its maturity and, thus, should rethink its role in the status that has actually been given to victims, then we can accept the proposal by Finkelhor regarding the possibility and need for Victimology dedicated to children and adolescents.

In his most recent work, American sociologist David Finkelhor (2007, 2008), Director of the *Crimes against Children Research Center*, Co-Director of the *Family Research Laboratory* and Professor at the University of New Hampshire, who has been dedicated to the study of child abuse and family violence, presents the arguments for a reconceptualization of what he calls a new domain of concern with child well-being: juvenile victimization. His proposal, which he has been working on with several segments of the population, is to try to reassemble some conventional ideas about abused children and compact, refine, and shape then into a more integrated, holistic and complex view of the problem.

For this, he proposes the unification of traditional subdivisions, for example, physical abuse, sexual violence, bullying, exposure to violence, which Finkelhor calls *Developmental Victimology.* Finkelhor (2007) advocates that *Developmental Victimology* is dedicated to the victimization of children and adolescents throughout their life, and proposes to integrate the various perspectives, regarding categorizing the victimization of children and adolescents, how to approach risk and impact factors and analyze the changes in victimization patterns throughout development. In the same vein, he proposes a new model for social and professional response to juvenile sexual victimization, "*Justice System for Underage Victims"* (Finkelhor, 2007), which presents itself as a useful model for professionals dedicated to helping victims.

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