Sexual Offending

What causes it, the role of mental illness and the effectiveness of Sex Offender Therapy
Session structure

Theories of Sexual Offending
- Finkelhor’s model of Child Sexual Abuse
- Hall and Hirschman Quadripartite model
- Marshall and Barbaree integrated theory of child sexual abuse
- Good Lives Model

Mental Illness and Sexual Offending
Effectiveness of Sex Offender Therapy
Finkelhor’s Precondition Model (1984 - )

- Four preconditions
  - Motivation to sexually abuse
  - Overcome internal inhibitors
  - Overcome external inhibitors
  - Overcoming the resistance of the child

- All preconditions must be met for abuse to occur
Pre condition: Motivation to sexually abuse

- Emotional congruence
  - Child satisfies important emotional, non-sexual needs of the perpetrator
  - Dominance (Howells, 1979)

- Sexual arousal
  - Not all child offenders show a deviant profile

- Blockage
  - Obstacles that prevent development of socially acceptable sexual interactions, e.g.
    - Inadequate social skills
    - Poor relationship development/maintenance
Pre condition: Overcoming internal inhibitors

- Disinhibited behaviour
  - e.g alcohol, anger, psychosis

- Mainly behavioural
Pre condition: Overcoming external inhibitors

- Situational/environmental factors
  - Must be overcome for abuse to take place
  - Can involve absence/illness of carer, poor parent/child bond, isolation of family from others
- Strongest, most reliable of Finkelhor’s pre-conditions
Pre condition: Overcoming Child Resistance

- Child compliance must be achieved in order for the abuse to occur. These can include:
  - Child’s emotional insecurity
  - Lack of sexual knowledge in the child
  - Coercion and grooming
So what are the problems with the model?

**Alcohol**
- Role in offending not clear
- Ignores role of cognitions as disinhibitors
  - e.g. cognitive distortions
- Anger more of a precursor in rape than child offences

**Disinhibition**
- Important in the initial development of abuse but not its maintenance
So what are the good things about the model?

- Ground-breaking!! – first multi-factorial model
- Looked at internal and external factors
- Includes a number of approaches (e.g. psychodynamic, attributional) – although, a little too many!!
- Offered a framework upon which to base clinical interventions
Hall and Hirschman’s Quadripartite model of child sexual abuse

- Four factor model
- Originally focused on rape, before its extension to child sexual abuse
Factor 1
Physiological sexual arousal

- Primary motivator of offending
- Deviant sexual urges and fantasies
- Most likely found in offenders who commit large numbers of offences against children
- Treatment involves behaviour modification for deviant sexual arousal
Factor 2

Cognitive distortions

- Justify their offending behaviour
- Victim blame
- Excusing sexually abusive behaviour
- Most dominant in offenders who commit offences within the family (incest)
- Tend to misinterpret child’s behaviour, perceive sexual intent and show good planning
- Treatment involves management of perceived sexual entitlement and other distortions
Factor 3
Affective dyscontrol

Emotional regulation

- control and management of emotion
- Poor regulation = problem behaviours
  - e.g. over-use of sex as a coping strategy
- Negative emotions (e.g. depression/ anxiety in child sex offenders can prevent the development of empathy
- Most dominant in offenders who show an impulsive and unplanned approach
- Treatment involves learning to control and regulate their emotions
Factor 4
Personality factors

Result of adverse early experiences
- e.g. child sexual abuse, disruptive upbringing
- Adverse early experiences lead to poor socialisation, development of antisocial attitudes and distorted thinking
- Not clear how these factors lead to offending
- Most dominant in offenders who have intimacy deficits/social functioning problems
- Therapy is intensive, looking at schemas
Whilst each factor contributes, one is more prominent (the primary motivational precursor)

- e.g. offender has arousal to a child (physiological sexual arousal) and an over-riding belief that sex with a child is acceptable (cognitive distortions/personality problems). YET an offence is not committed UNTIL they feel depressed (affective dyscontrol being the more prominent contributor - acting as a catalyst)
So what are the good things about this model?

- Introduces the notion of multi-factors
- Introduces the notion of early experiences
- Introduces the idea of a critical threshold before offending occurs
- Acknowledges individual differences
So what are the problems with the model?

- Theory underpinning the model never been systematically evaluated
- Examines psychological factors, ignores environmental/cultural influences
- Not clear if all factors are required to some degree for an offence to occur, or if they are optional
  - IF this is the case, its is a single-factors model NOT multi-factorial
So what are the problems with the model?

- Seems simplistic that only one factor ‘drives’ the offending
- No notion is given as to how factors interact
- Each of the four factors are really only explained in general and simplistic terms
  - Are cognitive distortions a cause of offending, or are they more a means to allow offending to take place?
  - What about the different types of cognitive distortion?
So what are the problems with the model?

- Each of the four factors are really only explained in general and simplistic terms
  - Ignores the complexity of deviant sexual arousal
  - Are cognitive distortions a cause of offending, or are they more a means to allow offending to take place?
  - What about the different types of cognitive distortion?
Marshall and Barbaree’s integrated theory of child sexual abuse

Marshall and Barbaree (1990)
Revised, Marshall, Anderson and Fernandez (1999)
Developmental vulnerability factors

- Insecure attachments
  - Poor parenting
    - Lead to a failure to explore, take risks and develops a mistrust in others
    - Linked to poor mood management, low self-esteem, poor problem-solving and poor self-worth
    - Lead to an individual's fear to disclose feelings etc in adulthood, seeing the world as a hostile place

- Inappropriate role-modelling
  - If sexually abused as a child, and perceived this to be rewarding (as a result of grooming etc), could foster later beliefs that sex with children is okay and normal
  - Also over-sexualising relationships from childhood experiences
Developmental vulnerability factors

Transition from child to adolescent is crucial

Puberty is critical for the development of sexual scripts (e.g. what is okay and not okay), sexual interests and beliefs

- Poor childhood experiences can leave an individual deficit in the necessary social skills needed to develop and maintain intimate relationships
  - Consequently, attempts to achieve intimate relationships can be met with rejection
  - Deficit social skills etc can lead to children being seen as more viable, as they are less likely to reject
Developmental vulnerability factors

- Dysfunctional early experiences can lead to regarding sex and aggression as the same
- Poor self-regulation skills as a result of poor social skills etc can lead to difficulties in managing appropriately their sexual urges. e.g.
  - Development of deviant sexual fantasies
  - Commit rape in order to gain sexual gratification (as deficit in the skills to seek an intimate relationship)
  - Belief that sex equates to a relationship (e.g. see the victim as their ‘partner’)
Are sexual offences (including deviant fantasies) just about sexual gratification?

- Does provide a releases of sexual tension, **BUT** also;
- Can increase sense of personal effectiveness and control
- Increase interpersonal closeness
- Increase self-esteem
- Increase feelings of masculinity (based on dysfunctional beliefs – hyper masculinity - dysfunctional belief that men are superior to women, women as sexual objects)
Situational factors

- Includes factors such as stress, intoxication and sexual stimuli (presence of a victim etc)
- Any individual can be at risk of committing a sexual offence, BUT the greater the level of vulnerabilities possessed, the less able the individual is to deal with stress, and the more chance of a sexual offence occurring (Marshall and Barbaree, 1990)
- Sexual offending can be reinforcing
  - e.g deviant fantasies continue to be reinforced through masturbation or committing offences.
Summary

Marshall and Barbaree’s (1990) model identifies vulnerability risks toward sexual offending (develop as a result of developmental issues, and which interact with situational factors). These risks include:

- Antisocial attitudes
- Poor self-regulation skills
- Low self-esteem
- Poor sense of identity
- Poor intimacy skills
- Difficulty in separating aggression from sex
- Poor perspective taking
- Poor coping skills (such as using deviant fantasy to deal with feelings of poor self-worth)
What are the problems with the model?

- Looks at sexual offending **general** terms
  - Does not allow for the specific differences within groups (e.g. different types of child offender)
- DOES offer different offence-pathways, BUT these are not clearly visible in the model
- Talks of sex and aggression being linked, but not all offences are aggressive in nature
  - In some child offences the offender perceives the offence to be ‘loving’
What are the good things about the model?

- Demonstrates sexual offending to be a contribution of factors that are interactional in nature
- Introduces the idea of vulnerability factors
- Looks at the origins of offending
- Identifies workable treatment areas, e.g. self-esteem, intimacy deficits
Girls Wanted
Young Attractive females needed on a part time basis
Many positions available!
Good Lives Model

Key issues

- Positive and productive life styles that move away from offending (life enhancement)
- New pathways rather than avoidance of old
- Risk factors are obstacles that block the capacity for a positive lifestyle
- Emphasis is about developing the skills to reach good lives rather than managing risk
- Approach goals rather than avoidance (Mann et al, 2002)
- Currently a theoretical model
Case Example: John
Risk Management versus Good Lives

- John struggles to develop intimate relationships with adults, is socially quite isolated and tend to be a bit of a loner, has frequent times of depression and is aroused by children.
- He lacks the skills and opportunities to secure his basic needs (in this case appropriate and caring attachments, intimacy and self-worth).
- As a result, he turns to children as they offer this attachment and intimacy, and belief that he feels valued.
Case Example: Peter
Risk Management versus Good Lives

**Risk Management strategy**
- Avoid contact with children
- Leaves a void in the offenders life

**Good Lives strategy**
- Look at ways to develop appropriate adult attachments and intimacy e.g. sexual knowledge training, relationship skills
- Engagement in appropriate activities that promote self-worth, e.g. work
- Must be realistic (e.g. trying to develop intimacy may not be the first step, but developing friendships would)
So what are the good things about the model?

- Individual in its outlook
- Motivational in its approach
  - Treatment Need
  - Non-avoidance based
- Focuses on intervention
Mental Illness and Sexual Offending
Should we assume all sex offenders are mentally-ill?

Whether sex offenders may, indeed, be classified as mentally-ill has been the subject of clinical observation and debate for years. Most clinical research to date concludes that sex offenders do not typically suffer from a major mental illness. Sex crimes are sometimes committed by persons who have psychotic illnesses. Such illnesses may in some cases be a contributory factor to the sexual offense, may compound an existing sexual abuse problem, or create a higher risk for the individual who behaves this way. Therefore, it is critical to understand that, in general, if a sex offender suffers from a major mental illness, the offending behavior is present in addition to, not because of the existing mental illness. We must be careful when describing sex offenders as "sick" or "mentally-ill", so as to avoid implying that the offender has an excuse for his behavior.

Honey-Knopp, 1984
What are the relationships between mental illness, sexual offending and risk?

- Are predictors of recidivism, for mentally disordered offender different from non-disordered offenders?

- Is offending amongst mentally disordered groups a function of their pathology?

- What is the research evidence?

- Why are relationships between mental illness sexual offending and risk important?
What is the Debate?

- Early reviews concluded the role of mental illness was not important
  - Factors relevant to the prediction of criminal and violent behaviour among the mentally disordered were the SAME as in non-mentally disordered populations (Monahan and Steadman 1983)
  - Yet, others argued that criminal and violent behaviour among psychiatric patients, especially schizophrenics is a function of their pathology (Jones 1992, Taylor 1985)

- Whilst the destabilising effects of mood disorders can be considered, their contribution to known risk factors such as employment, emotional loneliness have not been specifically researched
Sexual Offending as a Function of Pathology

What about ‘Delusion-Driven’ Offences?

- Jones et al (1992)
  - The study had a very small sample, n=4
  - Participants attempted and in one case succeeded in sexually assaulting women as a “direct response” to auditory hallucinations

- Sahota and Chesterman (1998) noted:-
  - It is difficult to draw conclusions about different phenomenology given the small sample size, EXCEPT that individuals who admit to command hallucinations MAY act on them
Sexual Offending as a Function of Pathology

What about ‘Delusion-Driven’ Offences?

- Determining whether a specific action or chain of behaviour, such as a sexual assault, is or is not due to a delusion requires an element of observer judgement (Smith and Taylor, 1999)

- **Smith and Taylor (1999)**
  - Acknowledged that even in the case of men with auditory hallucinations that gave explicit instructions to rape, a range of other factors such as the individual’s resistance to comply with the commands and situational variables determine whether the assault will be carried out
Individual Studies

Not possible based on previous studies to decide whether a diagnosis of schizophrenia increases the risk of sexual violence Rice and Harris (1992)

- Identified that the methodologies of studies looking at mental illness and offending are confounded by different criminogenic factors in the comparison groups (e.g. criminal history, age and index offence)

- Rice and Harris conducted their own study carefully matching 96 pairs of subjects. Matched DSM III schizophrenic (S) and non-schizophrenic (NS) groups by age, seriousness of index offence and criminal offence history
Individual Study cont’d

Sample

- Schizophrenic (S) group were from a maximum security hospital
- Non-schizophrenic group (NS) group were assessed in the maximum security hospital and returned to prison

- Recidivism – defined as any act which caused a return to hospital but for which the patient could have been criminally charged
What was the relationship between recidivism and schizophrenia?

<table>
<thead>
<tr>
<th></th>
<th>schizophrenia group</th>
<th>non- schizophrenia group</th>
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<tbody>
<tr>
<td><strong>General Recidivism</strong></td>
<td>35%</td>
<td>53%</td>
</tr>
<tr>
<td><strong>Violent recidivism</strong></td>
<td>16%</td>
<td>24%</td>
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</tbody>
</table>

- S recidivated significantly less for general recidivism.
- Non significant trend of less recidivism for violence in s group.
- (Maybe because alcohol problems were significantly less in the NS group).
- Also much less supervision for NS group on release.
Individual Study Cont’d

Developed a severity of psychopathology scale to measure psychopathology at the time of the offence

This included:
- Emotional problems
- Severe emotional problems
- Receiving psychiatric treatment
- Delusional motive for the index offence
- Elevations on scales 6 and 8 on the MMPI
- Being seen as lacking insight by a clinician

Results
- Scores on this scale differed between the S and NS groups but not found to be related to recidivism
Meta Analysis

Are Predictors of recidivism, or risk factors, for mentally disordered offenders different from non-disordered offenders? A meta-analysis was conducted to answer this very question by Bonta, Law and Hanson (1998).

They looked at clinical variables and their relationship with general and violent recidivism.

General Recidivism - defined as any evidence of a new criminal offence (arrests convictions or return to hospital for law breaking.)

Violent recidivism - defined as re-offending of a violent nature
Meta Analysis cont’d

<table>
<thead>
<tr>
<th>Clinical Variable</th>
<th>Relationship with recidivism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorder</td>
<td>Non-significant relationship</td>
</tr>
<tr>
<td>Psychosis and Schizophrenia</td>
<td>Negative relationship</td>
</tr>
<tr>
<td>Treatment history</td>
<td>Non-significant</td>
</tr>
<tr>
<td>Antisocial PD</td>
<td>Significant</td>
</tr>
</tbody>
</table>
Meta Analysis cont’d

- Bonta, Law and Hanson concluded
  - “Clinical factors other than PD have little relevance to the assessment of recidivism”
  - Although it could be argued that this is not the case, (if schizophrenia and psychosis are associated with reduction in recidivism).
  - Risk factors for both general and violent recidivism are the same” i.e. age, aspects of offence history, variables of psychosis and schizophrenia had a small effect size
  - It needs to be borne in mind that criticisms about the problems of not having matched groups in this field may be relevant here
What is the Relationship between Sexual Offending, Mental Illness and Risk?

- People with schizophrenia/psychosis recidivate less than people without (Hanson, Bonta and Law, and Rice and Harris)
- The Criminogenic risk factors are the same (Hanson, Bonta and Law)
- How can these findings be reconciled?
  - The literature suggests that people with mental illness are a lot better supervised and have more supervision opportunities than those without mental illness
Why is the Relation between Mental Illness, Sexual Offending and Risk Important?

- Need to understand the links to manage people’s risk on release and inform direction for treatment
- Discussing psychiatric management of the psychotic sexual offender in high secure hospitals

*Offending may be ascribed to the psychosis and effectively ignored on the assumption that the risk disappears with the symptoms of mental illness.*

- This can have grave consequences (Case X)
Conclusions/Questions

- If we treat mental illness this will help to improve coping skills (Bonta, Hanson and Law). It will also be managing a potential destabiliser.

- Need better assessment measures of psychopathology and their relationship to the index offence. There is no point giving the MMPI five years later.

- The effect size of psychosis/schizophrenia as a predictor in general is weak. This highlights the need for individual assessments as mental illness may be particularly destabilising for some individuals.
Conclusions/Questions

The whole area of risk prediction, is potentially confounded as the support offered to mentally ill patients is a lot greater than for prisoners post-release/discharge. We need to look at the recidivism of a prison population who are mentally ill and lack the support offered to those detained under the Mental Health Act.

- How much does a command hallucination derive from deviant sexual fantasy? Non mentally disordered groups talk about sexual fantasies becoming all-consuming. The cause and effect relationship between sexual fantasy and hallucination/delusions does not seem to have been researched.
Effectiveness of the Sex Offender Treatment Programme (SOTP)
STEP Team (1998)
Immediate impact of SOTP treatment

- Towards end of treatment offenders had less distorted thoughts (e.g. pro-offending attitudes), higher self-esteem (e.g. increased socially competence), and took more acceptance for their behaviour.

- The above improvements made the offender indistinguishable from the general population towards the end of treatment - “TREATED PROFILE”
Treated Profile
(attitudes, beliefs etc. indistinguishable from the general population)

- Of the low deviancy group who were in less denial of the offence less, 84% showed a reduction in levels of distorted thinking, denial of the impact of the abuse on the victims, fixation on children and use of justifications for their behaviour, compared to 43% of high deviancy men
Long-term findings (9 months after treatment)

- Men who had showed significant reductions through treatment (e.g. became less distorted in their thinking and took more responsibility) demonstrated no deterioration in these long-term

- Men who showed no changes in the above throughout treatment quickly lost their relapse prevention skills
Discharge into the community

Men discharged into the community maintained improvements gained through treatment (e.g. increase in openness, less distorted thinking and used less justifications for their behaviour)

Review of literature

- Randomised controlled trials (Cochrane acknowledges that such trials when assessing effectiveness of sex offender therapy can be seen as unethical)

- Disappointing review
  - Old literature and models of sexual offending
  - Only based on 3 studies – small sample size in one (31), one sample size unknown and other relatively substantial (231)
  - Talks of non significance, yet data examined and in what manner is unclear

- Convicted sex offenders and those with disorders of sexual preference
  - Not clearly define the differences between ‘sex offenders’ and those with ‘disorders of sexual preference’.

- Old literature
  - Relapse prevention Therapy (Marques, 1994)
  - “No discernable effect on outcome of sex offending”
  - Outcome data limited
  - Therapy based on old concepts (e.g. relaxation training, leisure/recreational activity)

Old literature

- Romero (1983) – group therapy had no effect on sex offenders recidivism at ten years
- Used mixed convicted sex offenders
  - Useful to separate these out
- Significant problems with recidivism data
  - need a large sample (this sample = 231)
  - Research now beginning to move away from this
  - Recidivism data itself is not accurate

- Makes reference to a lot of behavioural interventions
  - Current view is that such interventions are NOT effective in isolation, due to the complexity of sex offending
- Antilibidinal medication
  - Aimed to reduce sex drive
  - Sexual offending is not just about sexual gratification
  - Cochrane recognises this as limited
Friendship, Mann and Beech (2003)

- Evaluated effectiveness of SOTP in terms of recidivism using reconviction rates
  - Had the largest number of clients who had gone through sex offender therapy:
    - 647 adult male offenders who had participated in the SOTP (1992 – 1994) and discharged and in the community for at least 2 years
    - Comparison group of 1,910 adult male offenders who had committed a sexual offence
  - Based on old CORE SOTP
Results

Combined results of old and revised SOTP

- 2 year sexual re-conviction rate for treatment group and comparison group was low
  - Only a 5% reconviction rate for untreated sex offender within 2 years of release
  - Therefore, makes it difficult to find significant differences
Results

• **BUT**, there was a 58% reduction in the chances of the clients being reconvicted within 2 years for a sexual and/or violent offence if they had undergone therapy.

• High-risk offenders are 5 times more likely to be re-convicted for a sexual/violent offence within 2 years than low-risk.

• Use of sexual reconviction rates to evaluate effectiveness is unrealistic (due to low rates).

195 adult male sex offenders (prison)
- 56 completed treatment
- 49 entered treatment but did not complete
- 90 refused treatment

- 6 year follow-up, sexual re-offence rate:
  - 5.4% for treatment completers
  - 30.6% for part-treatment completers
  - 30% for no treatment group