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Psychology and Offending Behaviour

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'Most sex offenders can successfully be managed in the community.' Discuss with reference to research into the effectiveness of various forms of treatment.

Introduction

In addressing this often emotive issue the target group will be identified in quantifiable terms thereby demonstrating a clear and unambiguous premise that 'most' is a figure that has a degree of certainty. Having established this faction and the terms of reference that engage with inclusion, the effectiveness of available contemporary forms of treatment will be reviewed alongside the suitability of provision within the context of community care. Key principles will be defined and an illustrative case study will form a critical review.

Where necessary elements appertaining to the measurement of offending and how some offenders may seek to discredit forms of treatment will be explored in order to provide a comprehensive account of the diligence required when offender rehabilitation is sought.

In conclusion these strands of research will be articulated in order to support the headline notion that most sex offenders can successfully be managed in

the community.

Offender groupings

Over ninety percent of offenders within this category who carry out sexual crimes against the most vulnerable group of victims (16-19 year old women) are known associates of the aggrieved. This group range from partners and ex-partners through to intimate liaisons, dates and acquaintances. (Myhill and Allen, 2002). This data tends to distance the principal group of offenders from the distorted Hollywood vision of the unknown 'sexual slasher'.

Arguably this group may be defined as 'most' and in doing so provide persuasive evidence that this category is tangible, thereby allowing a gateway to the consideration of treatment for the vast majority of sex offenders. As this arena is explored the treatment will be identified, along with the associated methodology before commentary on the issue of community engagement is addressed.

Sexual offences per sae embrace a wide variety of misdemeanours including, for example, rape, sexual assault, buggery, gross indecency paedophilia and indecent exposure.

Treatments

The inability to form cohesive social networks is symptomatic of sexual offenders. Typically shortcomings in confidence, self esteem, anger

management and communication skills fuel this trait albeit the lack of empathy is also a significant characteristic.

The results of hostility toward women among 32 rapists, 28 non-sexual offenders, and 40 non-offender males indicated that rapists were significantly less empathic than either of the other two groups toward women who had been sexually assaulted by an unknown assailant. They were also significantly less empathic toward their own victims than toward any other women, and they were markedly more hostile toward women than were the other subjects. Finally, among the rapists, hostility toward women was significantly related to their negative empathy toward their own victims (Marshall & Moulden, 2001).

It is contended that as a fragment of potential treatment social skills and the needs of others can be addressed within the community through interpersonal skills training, mentoring or coaching. It must be reinforced that this deficiency may form only part of the overall treatment however it nonetheless remains within the ambit of community rehabilitation.

Cognitive behavioural techniques

The more aggravated areas of causation engage with cognitive distortions and sexual preferences and deviant offender arousal. The former describes the patterns of thought that offenders create in order to rationalise the crime as a normal consequence of the prevailing circumstances.

This concept is the guiding principle behind cognitive therapy, a type of psychotherapy developed by psychiatrist Aaron T. Beck in the 1960s ("What Are Cognitive Distortions?" www.about.com). In a nutshell cognitive distortions are logical, but they are not rational ("Definition of Cognitive Distortions," www.uwec.edu).

The latter object is framed around the offenders preferred state of stimulation that promotes the commission of the sexual act. Both of these factors will be explored independently however it is perhaps prudent at this juncture to register such causal features against a framework of measurement that may emphasise the level of deviance.

One such method is penile plethysmography. Briefly, the penile plethysmograph is a machine for measuring changes in the circumference of the penis. A stretchable band with mercury in it is fitted around the subject's penis. The band is connected to a machine with a video screen and data recorder. Any changes in penis size, even those not felt by the subject, are recorded while the subject views sexually suggestive or pornographic pictures, slides, or movies, or listens to audio tapes with descriptions of such things as children being molested. Computer software is used to develop graphs showing 'the degree of arousal to each stimulus' ("Penile Plethysmograph," www.skepdic.com).

As a means of measurement it does, however, have its limitations and can be manipulated by individuals minded to disrupt the process by engineering predetermined responses. One of the most explicit examples of this ability, pshchopathy, will be addressed later in this review.

Deviant arousal can be treated via a number of cognitive behavioural techniques. Principally these engage with masturbatory reconditioning, of which there are two forms (verbal and masturbatory satiation), aversion therapy and relapse prevention.

The primary goal of verbal satiation is to reduce deviant arousal by repeating verbalised deviant fantasies. As this method is reinforced over and over again, the fantasies become more tedious and therefore lose their arousal value. In masturbatory satiation, the offender masturbates to ejaculation to a non-deviant fantasy and then must continue to masturbate to deviant fantasies following ejaculation. The discomfort associated with this practise again seeks to reduce the arousal factor. This is emphasised by the necessity to repeat this process for at least twenty treatment hours (Abel and Blanchard, 1974).

A review of the research conducted by Marshall and Barbaree reported that there was positive evidence of the effectiveness of satiation therapies and the researchers believed that the techniques should become a standard treatment option within the arena of work with sexual offenders (Marshall and Barbaree,

1978, p. 303).

A variety of aversion therapies exist including, for example, the use of smells and electricity. Examples of the former include smoke, ammonia and the odour of putrefying tissue. As an example of the latter, Quinsey, Bergensen and Steinman (1976) used electric shock aversion therapy with ten child molesters and reported a significant increase among the sample in sexual preference for adults over children.

Quinsey, Chaplin and Carrigan (1980) treated 18 child molesters, using biofeedback and signalled-punishment aversion therapy with electric shock, and reported promising results. There are a number of advantages in using odours as their introduction can be precisely timed to during the duration of the deviant arousal stimuli (for example, slide, video, or story line). Little technical equipment is necessary and patient buy in is relatively high (Maletzky, 1991, p. 81).

Relapse prevention allows offenders to recognise the steps that, when taken to their ultimate conclusion, will lead to re-offending. In general terms these stages follow the pattern of thoughts, masturbatory action and justification of deviant behaviour to actual re-offending.

A comprehensive study of various cognitive treatments engaging with over a thousand participants reported recidivism rates reduced from 16.8% to 12.3%

when compared to a non-treatment group (Hanson, Gordon, Harris, Marques, Murphy, Quinsey and Seto, 2002).

Furthermore older forms of treatment (pre-1980) such as psychoanalytical treatments had little effect (McGuire,1995).

Perhaps the golden thread of success has as much to do with the buy in by the offenders as the treatments alone (Seto 2003). Thus, re-offending rates are lower for those participants who complete the treatment than those who fail to go the distance. A word of caution could, however, be endowed upon those offenders who exhibit pshchopathy to complete the programme and in doing so fail to change their inner most values and deviant behaviour (Hare 1991).

Within the terms of the Mental Health Act the term psychopathic disorder is defined as, ‘a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct’, (Mental Health Act 1983). The clinically defined personality disorders of anti-social personality disorder (ASPD) and dyssocial personality disorder include traits which are often seen as psychopathic (for example, callous disregard for others, irresponsibility and lack of empathy) and therefore could provide a medical definition of psychopath. However, the lifetime incidence of ASPD appears to be around 3% of the population (Girolamo & Reich, 1993) which would arguably seem to

be too high to apply such a damaging label to. There are clinical tools which appear to identify a type of personality which are labelled psychopathic. The most direct of these is the Psychopathy Check-List which rates a variety of behaviours and personality traits and scores individuals as either psychopathic or non-psychopathic (Hare, 1991).

In addition to these legal and clinical definitions there is also the social definition of psychopath. Appearing in works of fiction and urban legend the psychopath is the dangerous killer; remorseless, cunning, invisible and wholly evil. 'Psychopaths…are ruthless social predators.' The word itself is perhaps loaded with emotional content and 'if one thing is clear about the label of "psychopath" it is that it is a term of opprobrium' ("The treatability test," www.markwalton.net).

Finally, another, perhaps draconian, treatment (proactively used within the United States) is chemical castration. Essentially this treatment is the equivalent of physical castration using drugs such as Cyprotene Acetate and Medoxyprogesterone Acetate. Although a sustainable and community based treatment there are nonetheless serious side effects for the patient including depression and significant weight gain.

It is contended that all of the hitherto examples of treatment can be and have been facilitated within a community based context.

Cognitive behavioural treatments – An indigenous community based case study

The Home Office Research and Statistics Directorate research paper number 45 (October 1996) robustly engages with the headline issue of – 'Does treating sex offenders reduce re-offending?'

As a vehicle of review it is arguably one of the most emphatic examples of community based success.

Overview

A two-year study engaged with the re-offending rates of sex offenders who participated in community treatment. The research formed part of phase three of STEP – A three stage evaluation of sex offender treatments.

Key findings

- Positive affect on the attitudes of sex offenders and more importantly their recidivism rates.

- When contrasted to sex offenders placed on probation in 1990 those who took part in the seven programmes evaluated by the research team were less likely to be reconvicted for a sexual offence by a factor of 80%.

- Of the STEP offenders who committed further offences, only 54% committed a further sexual offence.

- All, bar one, of the sexual reconvictions were for a similar or less serious offence.

- None of the twenty four offenders who were assessed as having been significantly treated had been reconvicted within two-years. This included nine who were assessed as being 'highly deviant' before the treatment had commenced.

(Research findings No. 45, October 1996, page 1)

STEP programme – A synopsis

Phase one

Initially the research team reviewed current studies into the success of programmes in both Europe and North America. In union a review of programmes operated by, or in conjunction with, probation services in England and Wales was also undertaken.

This primary stage revealed that cognitive behavioural approaches were the most likely to succeed, especially those that taught offenders to reflect upon their thoughts and feelings towards their victims along with addressing their patterns of offending. These methods provided successful with behavioural

controls to eliminate further offending.

Domestically, in England and Wales, the vast majority of programmes adhered to cognitive behavioural therapy (Barker and Morgan, 1993).

Phase two

Seven indigenous community based projects were selected for further intensive scrutiny by a team of research psychologists (Beckett et al. 1994). In a nutshell the programmes were made up as follows –

4 short term programmes;

2 longer 'rolling programmes;

1 private residential scheme (lasting for 12 months).

Offender deviancy levels were assessed prior to engagement (table 1 below) with the programme and at the conclusion. Some of the key issues measured at this juncture included empathetic responses to victims and sexual compulsion.

Table 1: Current and previous convictions for sexual offences (for participants on a treatment programme)

Offence	Current – main offence		Current – other sexual		Previous sexual	
	N	%	N	%	N	%
Indecent assault	96	72	16	12	37	28
Buggery/attempted buggery	11	8	3	2	10	7
Rape/attempted rape	8	6	1	1	0	0
Incest	5	4	3	2	3	2
Gross indecency with child	2	2	21	16	12	10
Unlawful sexual intercourse	5	4	1	1	1	1
Indecent exposure	3	2	1	1	4	3
Other (non-notifiable)	3	2	0	0	3	2
Total offenders	133	100	46		70	

The second phase review, not surprisingly, found that the longer term residential programmes had a greater success. This was due to the fact that these treatments (with an average of 462 hours per individual) were up to eight times longer than other treatment times. However, it should be noted that this group included many of the highly deviant child molesters as opposed to offenders who exhibited much broader offences on other programmes. On the other hand, probation run programmes had moderate success with low deviant offenders, but hardly any on the highly deviant group.

In general these schemes allowed offenders to understand their problematic behaviour albeit had limited success in assisting them to develop new patterns of behaviour to reduce future risk.

Phase three

Centred upon the re-conviction rate after the conclusion of the community based treatments. In this case the period under observation was for a period of two years, encompassing a review of data from the seven treatment centres and statistics on previous re-offending from the Home Office Offenders Index (table 2 below).

The limitations of this of this data must, however, be disclosed at this juncture, especially in relation to the follow up period. For example, six months is

considered prudent for burglars and it is arguable that two years may be too short. Indeed Lloyd et al (1994) recommended five years.

The class of sex offenders referred for treatment within the community (contained within table 1 above) engaged with a number of primary offences albeit the main share of convictions were for less serious offences. For example, indecent assault, exposure and other non-notifiable offences aggregated 76%. On the other hand the research showed that a high proportion of situations that were originally reported to the police as the more serious offence of rape resulted in a finding of guilt for indecent assault (Grace and others, 1992). Thus, it is submitted, the table must be viewed with a degree of reservation.

Nevertheless, approximately a third (41) had no previous convictions at all, 17% (23) had previous convictions for non-sexual violence and 20% (27) for the offence of burglary. One third (44) had previously served a term of imprisonment, 11 of which constituted a term of youth custody (2 of which followed a finding of guilt for a sexual offence).

Table 2: Two-year reconvictions

	Short term	Rolling long term	Long-term residential	All seven programmes	1990 probation sample
Sexual	1	1	4*	6 (4.5%)	17 (9%)
Non-sexual only	0	2	3	5 (4%)	38 (20%)
Not reconvicted	26	29	67	122 (92%)	136 (71%)
Total	27	32	74	133	191

NOTE: * In many reconviction studies, the most serious (principal) offence determines how the reconviction is classified. The principal offence for one of these offenders was burglary; however, as he was reconvicted at the same court appearance for a sexual offence (unlawful sexual intercourse), he has been included in the sexual reconviction group.

8% (11) of the 133 offenders had been convicted within the 2-year evaluation period. Of these 6 were convicted of a further sexual offence whilst the remaining 5 were found guilty of non-sexual and non-violent offences.

The final column, it is contended, provides the most compelling evidence of the success of the STEP community based programme. The sexual reconviction rate of the 191 sex offenders given probation orders in 1990 is nearly 100% more than the STEP sample. This outcome is even more impressive given the fact that the results (for both groupings) were analysed via the Offender Group Reconviction Score algorithm (OGRS), a process that forecasts the likelihood of an individual reoffending for any offence within the review period whilst taking into account key differentials such as age, previous violations and periods of incarceration. In conducting this flattening out process the actual rate of reconviction for the STEP group was 9% (lower than the predicted OGRS score of 13%) whilst the actual rate for the 1990 probation sample was 29% (higher than the OGRS score of 23%).

Conclusion

Once the subjective hysteria of locking away sexual offenders is removed from the equation it is submitted that the community based treatment programmes have a positive and tangible affect on sexual reoffending rates as opposed to the more traditional criminal justice routes such as probation. The latter punitive programmes essentially seek to punish rather than engage with the issues that lead up to the commission of the crime.

Cognitive behavioural techniques on the other hand connect with the fundamental drivers of sexual deviancy and although vulnerable to the more psychotic and sophisticated offenders the results are nonetheless empirically sound and impressive. Of course the buy in of those offenders on the treatment programmes is essential although it is arguable that the vast majority of offenders complete the programmes, as the STEP intervention, albeit limited in numbers, clearly demonstrated. The interpersonal skills necessary to examine the relation between offenders and would be victims and the self reflection needed to review the route away from reoffending can be adequately facilitated within the community either in rolling events or residential schemes.

Equally the provision of other restrictive behavioural techniques within the community is merited. The more drastic chemical based solutions can be delivered within a non-custodial environment allowing the more serious offenders to be neutralised and monitored.

Of course the critics will point to evidence of some offenders simply 'playing the game' whilst engaged on a particular programme. Although, perhaps, endemic of any form of correction the fact that, in some cases, community based resolutions saw a two fold increase in the success rate when compared to the more traditional punishment of, for example, probation is ample evidence of the overall return on investment.

In mid-1995 the Association of Chief Police Officers stated that there were over 3,700 sex offenders who were being monitored by the probation service and who resided within local communities. Over a third of this group were on post-release supervision whilst the remainder were serving a community imposed sentence (Proctor and Flaxington, 1996). Such numbers, it is contended, can only be successfully confronted by reliance on a cohesive cognitive methodology of treatment rather than simply placing restrictive orders that have little or no effect on offending behaviour.

Finally, it is submitted that the headline presumption is sustainable even though it may seriously conflict with the general public perception of sexual offenders especially where children are the ultimate victims. The balance between punishment and rehabilitation particularly in cases of a sexual nature is a challenging notion for the criminal justice system since it carries with it many subjective points of view.

This perception may be fuelled by the media and television. On the one hand

there is evidence of adolescent humour attached to some sexual offences. For example, 'Zip Me Up Before You Go Go' (1998, 9th April. *The Sun* www.news.bbc.co.uk) relating to the singer George Michael for his lewd behaviour in a public lavatory in Will Rogers Memorial Park in Beverly Hills. On the other, more provocative statements such as 'Terror on our Streets' (2006, 13th December *The Guardian* www.guardian.co.uk) relating to the sexually aggravated murders of prostitutes in Ipswich.

As a parent of two I may not, however, be so affording to such rehabilitation if my offspring were the innocent victims of a sex offender.

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