RISK, RECONVICTION AND THEIR RELATIONSHIP TO KEY DEVELOPMENTAL VARIABLES IN A COMPLETE URBAN SAMPLE OF CHILD MOLESTERS AND RAPISTS

Jackie Craissati

March 2003

A thesis submitted to the Faculty of Science of the University of Birmingham for the degree of Doctor of Philosophy

Department of Psychology

Faculty of Science

University of Birmingham

Birmingham, B15 2TT, UK

ABSTRACT

A good deal of attention has been paid to the question of recidivism in sex offenders, with a particular emphasis on identifying those variables which might best predict future risk. Despite growing interest in developmental variables, such as attachment and trauma, their relationship to risk in sex offenders has not yet been established. The aim of this thesis was to establish the extent to which developmental variables may contribute to a risk assessment model in sex offenders – based on fixed variables – with particular reference to treatability and failure in the community. A complete urban sample of 310 convicted sex offenders (child molesters and rapists) were studied, and followed up after an average period at risk in the community of four years. It was found that key developmental variables – childhood victimisation (sexual, physical and emotional), emotional/behavioural difficulties, and insecure attachments to primary caregivers – were significantly associated with a higher risk of recidivism and treatment non-compliance. An enhanced prediction model is proposed, which postulates that the presence of a combination of two or three of these key developmental variables – considered in conjunction with a static risk prediction level – is the key to determining risk of community failure.

ACKNOWLEDGEMENTS

I would like to thank a number of individuals who have made significant contributions to this thesis. Grace McClurg and Sara Falla have provided invaluable assistance in the collection of data, and in agreeing some of the more difficult definitions relating to the developmental variables. In particular, Tony Beech and Kevin Browne have contributed throughout this process in terms of advice and helpful contributions. I am grateful to [redacted], my employers, for encouraging me by providing practical support and resources.

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

In the past five years, a good deal of attention has been paid to the question of recidivism in sex offenders, with a particular emphasis on identifying those variables which might best predict future risk (Hanson and Bussiere, 1998). Currently, there are actuarial tools based on fixed or static variables (Hanson and Thornton, 1999) which have been validated, and are simple to use and accessible to a range of professionals. The pool of identified static variables repeatedly associated with recidivism risk in the literature, is fairly limited: these include the number of previous convictions, and specifically sexual convictions; the age of the offender; victim characteristics in terms of male gender, and being previously unknown to the offender; and single status. Two static risk prediction tools are widely used – Risk Matrix 2000 and Static 99 (Hanson and Thornton, 1999). These provide base-line assessments for predicting the relative risk of sexual recidivism in convicted sex offenders, both rapists and child molesters. Recently, attempts to develop similar procedures in the identification of key dynamic – changeable - variables are showing promising results in terms of enhancing the accuracy of static risk prediction (Beech, Friendship, Erikson and Hanson, 2002; Hanson and Harris, 2001). These dynamic approaches do consider offence-related factors, but also take into account a broad ranging consideration of psychological difficulties experienced by sex offenders, which have an impact on their social and interpersonal functioning. Preliminary results would suggest that there are four dynamic domains which can predict sexual recidivism, independently of static risk prediction: these include pro-offending attitudes, intimacy deficits, sexual self-regulation (including deviant sexual interests)

and general self-regulation. Those offenders presenting with a range of dynamic difficulties are considered to be 'high deviancy' offenders (Beech, 1998). A combined model of static and dynamic risk assessment would appear to yield optimum results, at this early stage in research, in terms of identifying those sex offenders at most risk of sexual re-offending.

There has been growing interest in the role of key developmental variables as antecedents in pathways to offending (Knight and Sims-Knight, 2002), particularly in the area of attachment styles in sex offenders (Ward, Hudson and Marshall,1996) and offenders' childhood histories of trauma and victimisation (Craissati and McClurg, 1997; Ward, Hudson, Marshall and Siegert, 1995). Their relationship to risk has not yet been clearly established, although a negative relationship with mother was the single developmental variable found by Hanson and Bussiere (1998) to be significantly associated with recidivism. Childhood difficulties which relate to attachment and trauma may also underpin the static variable of single status which, in turn, is likely to be linked to the dynamic domain of intimacy deficits. Attachment theory, as first postulated by Bowlby (1977), is a means of "conceptualizing the propensity of human beings to make strong affectional bonds to particular others" (p. 201), and that individuals construct working models in childhood, based on early experiences with significant others, which influence subsequent attachments.

Attachment experiences in sex offenders have begun to be studied (Marshall, 1993; Hudson and Ward, 1997), based on the premise that erratic and rejecting parenting behaviours, which alienate children from the possibility of forming secure attachment bonds, distinguish the family context in which sex offenders grow up. Although reported rates differ, sex offenders – particularly child molesters - appear to have

been sexually victimised in childhood more often than the general population or other types of offender (Weeks and Widom, 1998). Boys at risk of sexual victimisation are more likely to be targeted for abuse if they come from disrupted and neglected households, where poor attachments with parents, physical abuse and neglect may precede sexual victimisation (Hamilton and Browne, 1998).

Thesis

The thesis aims to establish the extent to which developmental variables may contribute to a risk assessment model in sex offenders – child molesters and rapists - with particular reference to questions of treatability and failure in the community.

More specifically, the thesis will

- Examine the predictive validity of two commonly used static risk prediction tools on a complete urban sample of convicted sex offenders, and the extent to which they can accurately predict 'sexually risky' behaviours, as well as recidivism.

- Explore the role of key developmental variables in relation to community failure – types of recidivism, attrition in treatment, compliance with statutory expectations and 'sexually risky' behaviours.

- Determine the extent to which there are similarities or differences between child molesters and rapists, in terms of childhood experiences of sexual victimisation and attachment to parental caregivers.

- Examine whether key developmental variables can enhance the predictive capacity of current static risk assessment tools.

The context for the research derives from two separate but overlapping agendas: first, the public protection agenda has led to the development of local Multi-agency Public Protection Panels (MAPPPs, Sections 67 and 68 of the Criminal Justice and Court Services Act, 2000) which have responsibility for the monitoring and management of registered sex offenders (Home Office, 1997) and potentially dangerous offenders. In an attempt to achieve consistency and defensible decision making, MAPPPs have largely adopted a static risk assessment tool (Risk Matrix 2000) to guide them.

The second agenda – evidence-based practice – is central to both the National Health Service and the National Probation Directorate, and it is within this context that treatment efficacy should be established, particularly if public protection is an issue.

The Challenge Project, a community assessment and treatment programme for sex offenders in South East London, is a partnership between the local forensic mental health service and the probation service. It includes a range of treatment programmes, including group work (and relapse prevention), individual cognitive behavioural treatment, and individual supportive psychotherapy. For the past eight years, data has been collected on all convicted sex offenders – child molesters and rapists - in the area, as part of the Challenge Project, who come before the Courts for sentencing or have been released back into the community. The data set is therefore a complete urban sample comprising 310 subjects.

Structure of the thesis

Chapter two examines preliminary data on the first 178 child molesters, with regard to their risk profile, the role of psychometrics, the types of failure, and the historical factors associated with failure.

Chapter three explores the comparative utility of two static risk assessment tools in predicting recidivism, 'sexually risky' behaviours, and non-compliance in the total sample of child molesters and rapists. Key developmental variables are identified which are associated with community failure, and enhance the predictive accuracy of the static tools.

Chapter four is a literature review of the recent work on dynamic variables relevant to sex offenders, and their relationship to risk prediction models. This review considers the relationship between dynamic domains and apparently fixed developmental variables, such as attachment and victimisation experiences.

Chapters five and six specifically focus on child molesters. Chapter five reviews the literature on attrition from sex offender treatment and explores whether offence-related, or historical psychological variables predicts attrition and non-compliance in the sample who entered the community treatment programme. One of the significantly predictive developmental variables – a history of sexual victimisation in childhood – was then explored in more detail in chapter six. Sexually victimised and non-sexually victimised child molesters were compared on a wide range of variables.

Support for significantly greater levels of psychosexual disturbance in sexually victimised child molesters was found.

Chapter seven aims to repeat the work of chapters five and six, but with the rapist sample. Data on offence variables, childhood victimisation and adult psychological difficulties are described, in comparison to the child molesters. Although the numbers of rapists in the community, and in treatment, were fairly small, preliminary results are reported, in terms of compliance and failure.

Having explored the significance of self-reported developmental variables, chapter eight links adverse childhood experiences to key themes in the attachment literature, at the root of which lies the individual's primary relationship with his caregivers. A psychometric measure – the Parental Bonding Instrument – was administered to both child molesters and rapists with the aim of measuring and comparing perceived parenting styles. The Addendum to chapter eight presents the results of an additional small study which aimed to establish meaningful comparison groups - violent (non-sexual) offenders and a locally recruited control group of non-offenders.

Chapter nine, the concluding chapter, provides a discussion of the results, draws out some overall conclusions, highlights some methodological limitations and indicates future directions for research.

CHAPTER TWO

A PRELIMINARY STUDY OF RISK AND RECONVICTION IN CHILD MOLESTERS

The aim of this chapter is to examine preliminary data on the first 178 child molesters, 153 of whom had been at risk in the community for an average of 36 months, and 91 of whom had entered the community treatment programme.

On the basis of the published sexual recidivism rates, it was anticipated that the base rate for sexual reconviction would be low, given the relatively short follow-up period. Nevertheless, an examination of the data provides some indication of the number and types of failure in the community, and the characteristics of these 'failures' (specifically, the relationship of childhood sexual victimisation to failure). It is important to ensure that there is a representative spread of risk levels in the sample, and to see whether sexual recidivists are rated as high risk on an actuarial tool. Given the investment of resources in the community treatment programme, it is essential to identify early indications of any problems in terms of treatment content or intensity which might require review or adjustment of the programme.

[p8-24]

Craissati, J and Falla, A and McClurg, G and Beech, AR (2002)
Risk, reconviction rates and pro-offending attitudes for child molesters in a complete geographic area of London. Journal of Sexual Aggression, 8 (1). pp. 22-38. ISSN 1355-2600

title: Risk, reconviction rates and pro-offending attitudes for child molesters in a complete geographic area of London
creator: Craissati, J
creator: Falla, A
creator: McClurg, G
creator: Beech, AR
subject: BF Psychology
date: 2002
type: Article
type: PeerReviewed

http://dx.doi.org/10.1080/1355260020841330

PAGES NOT SCANNED AT THE
REQUEST OF THE UNIVERSITY

SEE ORIGINAL COPY OF THE THESIS
FOR THIS MATERIAL

Key points

The results of this study confirm that the sample is representative in terms of demographic, offending and risk profile. As expected, the follow up period was too short to be able to determine any meaningful associations between a range of variables – including treatment interventions – and outcome. It seems likely that the relationship between treatment, community management and outcome is a complex one. There was little evidence for the use of psychometric self-report measures in determining a treatment profile or outcome. However, there were the first indications that a history of sexual victimisation might contribute to a risk prediction model, alongside offence-related variables.

CHAPTER THREE

RISK PREDICTION AND FAILURE IN A COMPLETE URBAN SAMPLE OF SEX OFFENDERS

The results presented in Chapter two clearly indicated the need to replicate the study with a larger sample size, and the use of enhanced risk prediction tools with established validity. In this chapter, it is now possible to compare the comparative utility of two static risk assessment tools – Risk Matrix 2000 and Static 99 – in predicting recidivism. There is also a longer period at risk in the community of 55 months; although sex offenders are known to continue re-offending for many years, the majority of recidivists are likely to offend within the first four years at risk (Hanson and Bussiere, 1998). The sample now includes rapists as well as child molesters, which allows for a detailed analysis of each subgroup as well as the sex offender sample as a whole. It is particularly important to examine the characteristics of rapists in relation to risk prediction, as it has been more difficult to establish clear and consistent characteristics in this group (Quinsey, Lalumiere, Rice and Harris, 1995).

An examination of 'failures' has now been enhanced, to include consideration of 'sexually risky behaviours', in an attempt to address legitimate concerns regarding the hidden nature of sexual offending and apparent difficulties in achieving criminal convictions. This category of community failure or concern has been defined so as to include 'intelligence' from key community agencies regarding the observed behaviour of sex offenders in the community. Given the continuing low base rate for sexual

recidivism, this was an important strategy in order to develop a meaningful predictive model for various types of community failure, which could be tested empirically.

Crucially, a range of key developmental variables are examined for the degree to which they are associated with community failure, and might enhance the predictive accuracy of the static tools. These developmental variables – in line with the literature – include the offenders' reported childhood experiences of abuse and neglect, and other emotional and behavioural difficulties during development.

Introduction

Considerable progress has been made in developing risk prediction tools for sex offenders (Hanson & Thornton 2000; Thornton, Friendship, Erikson, Mann and Webster 2002).

Such tools have been based on static or fixed, historical variables which are easily derived from file information. Based on consistent research findings, all validated tools have in common variables relating to sexual offence history, age, no cohabiting intimate relationships, male and stranger victims. Two actuarially based risk prediction tools are widely used in the U.K. The current assessment of choice is Risk Matrix-2000 (Thornton, Friendship, Erikson, Mann & Webster 2002). Level of risk can be derived from file information and an offender can be put into one of four risk categories: low, medium, high, very high.

Risk Matrix-2000 has widely superseded Static 99 (Hanson & Thornton 2000) in the U.K., although it is used widely in Canada and the United States. Static 99 comprises of four categories of risk: low, low-medium, medium-high and high. It has been validated on a number of diverse samples comprising child molesters and rapists.

However, there are limitations to statistically based prediction, for example: unreliability relating to the low base rate of offending in low risk offenders; difficulties in determining how an individual offender fits into the probability statement – for example, whether he is one of the 52% of high risk offenders on Static-99 predicted to re-offend within 15 years or one of the 48% who will not; by treating such assessments as a cumulative measure of

level of risk whether the meaning of individual variables in such schedules and their relationship to risk management is lost (Grubin and Wingate 1996). Also risk prediction schedules at the present time only take into account official previous offence history (i.e., convictions) and do not take into account allegations/ cautions and obviously cannot take into account undisclosed offences. Therefore because of these limitations, there is a strong possibility that an actuarial assessment (only taking into account historical items) may be anything from a low to severe underestimate of the risk a sex offender actually poses in the future.

In an effort to produce better estimates of risk, increasing attention is being paid to dynamic (changeable) variables which appear to be linked to risk of further offending and which are broadly clinically-based, i.e., looking at the current functioning of the offender, in terms of cognitive, affective and behavioural attributes. The aim of these approaches is to enhance the predictive validity of current static prediction tools, such as Static-99 and to measure change, as a result of treatment or management interventions, which meaningfully related and link ' to recidivism risk. Although a variety of psychometric and clinical observation approaches are utilised, research points to four consistent dynamic domains (see Chapter four, for a full review): pro-offending attitudes, socio-affective functioning, sexual self-regulation (including deviant sexual interests) and general self-regulation (including lifestyle impulsivity). These domains can be considered as measuring both stable (relatively enduring patterns of behaviours or cognitions related to offending) and acute measures (behaviours indicative of the high probability of commission of sexual offence) of dynamic risk. Acute variables do not have a clearly

established evidence base in the prediction of risk, although Hanson and Harris (2000) include them in their dynamic tool. They relate to changes in the month prior to assessment, and include substance misuse, negative mood, anger/hostility, and increased opportunities for victim access.

While there has been interest in the developmental and clinical histories of sex offenders (Bard, Carter, Cerce, Knight, Rosenberg and Schneider 1987; Craissati and Beech 2002; Dhawan and Marshall 1996), links between these and sexual recidivism has, to date, been patchy. In terms of these type of items Hanson and Bussière (1998) found that the sole developmental variable that had any predictive validity was a negative relationship with mother. In terms of clinical factors they found that personality disorder (including anti-social personality disorder) was related to sexual recidivism but no other variables of psychological maladjustment were found to have any significant effect. However, we have found (Craissati and Beech 2001; Craissati, Falla, McClurg and Beech 2002) that sexual victimisation in childhood, contact with mental health services as an adult, and two or more childhood difficulties[1] were predictive of failure in the community. Failure, in these studies, related to attrition from treatment, any reconviction, or recall back to court for failure to comply with statutory conditions. Indeed, previous studies found that personality disturbance was related to treatment dropout in sex offenders (Abel, Mittelman, Becker, Rathner, and Rouleau 1988; Chaffin 1992).

---

[1] including persistent truanting, school refusal, bullying, aggression, stealing, running away from home, deliberate self-harm, difficulties with peer friendships and marked feelings of misery

Attempts to determine the efficacy of treatment programs in reducing sexual recidivism have been fraught with methodological difficulties (Furby 1989; Marshall and Barbaree 1988). However a recent large scale review of treatment outcome studies (Hanson, Gordon, Harris, Marques, Murphy, Quinsey and Seto, 2002) concluded that there was cautious support for treatment having a small but significant effect on the reduction of sexual recidivism (from 17% to 10%) and any recidivism (from 51% to 32%). Hanson et al. also report that attrition in treatment was related to a greater sexual recidivism risk. However, interestingly treatment refusers (likely to include a significant group of total deniers) were not at a higher risk for sexual recidivism than offenders who started treatment, but were at relatively high risk for general recidivism.

Therefore the aim of this study was to look at some of these aspects of risk assessment, that is, whether one of the two risk assessment schedules commonly used in the U.K. is better than the other, whether existing tools can accurately predict a broader range of risky behaviours, not necessarily resulting in conviction; whether the consideration of developmental or clinical information is important in understanding the level of risk offenders present and the impact of treatment in the reduction of risk in a complete urban sample of convicted sex offenders residing in the community in S.E. London. No specific hypothesis was made regarding the comparison of the Risk Matrix 2000 and Static 99 assessment schedules. However the following hypotheses were made relating to developmental and treatment outcome variables:

1. There will be a range of background and developmental variables associated with both high risk status and failure in the community
2. Those undergoing a community treatment program will re-offend less than those not in treatment.
3. Both established risk tools and key background variables will be able to predict sexually risky behaviours as well as sexual convictions.

Method

Subjects

Over a seven year period, 310 subjects were assessed. The sample comprised 80 offenders against adults (rapists) and 230 child molesters, the larger number of child molesters being partly due to the first two years of the program excluding rapists from data collection. The research sample differed from those previously described, in that data were available on all convicted contact sex offenders – child molesters and rapists – resident in two boroughs in S.E. London. Demographic and background data have been extensively reported elsewhere for the child molesters (Craissati, McClurg and Browne, 2002a) and for rapists (Craissati and Beech 2002).

The data was compiled in collaboration with the local Probation Service. In 72% of the cases, the subjects were referred to a community assessment and treatment program for sex offenders for psychological reports, prior to sentencing or at the point of release from custody. A small number of offenders (5) with a primary diagnosis of severe mental illness (usually schizophrenia) were excluded from the entire analysis.

Procedure

Details of all subjects were obtained from the probation files and in discussion with probation officers. Additionally, information was gathered in a semi-structured clinical interview which covered personal and social details, a full history of offending behaviour, and monitoring of attitudes towards the offence(s). Witness statements and probation reports were available in all cases, providing a degree of corroborative information on a number of issues relating to the offending. All the background and offending variables were clearly defined and regularly checked by the researchers, particularly if there were doubts about the rating.

A number of variables were considered – on the basis of self report - which are associated with emotional or conduct disorder in childhood. These included ratings (before the age of 16) for persistent truanting or school refusal, significant episodes of being bullied or bullying others, suspension from school for aggression, stealing, running away from home, deliberate self harm, experiencing prolonged difficulties with peer friendships and marked feelings of misery.

Ratings of sexual, physical and emotional victimisation in childhood were based upon self-report in interview, and corroborative information was sometimes available in previous mental health and probation reports, or the prosecution evidence. Full details of these ratings are described in Craissati, McClurg and Browne (2002a).

Community treatment was available as a structured group treatment program; similarly structured individual treatment and miscellaneous individual treatment, broadly considered to be supportive psychotherapy was also available (see Craissati and Beech 2001;Craissati, Falla, McClurg and Beech, 2002, for a detailed description of treatment).

Two actuarially based risk prediction tools were used. Risk Matrix 2000 (Thornton, Friendship, Erikson, Mann and Webster 2002), is used widely in sex offending populations in England and Wales, and can be derived from file information. It comprises a simple baseline risk classification based on conviction data, adjusted at stage two if two or more aggravating factors are found (for example, male or stranger victims). Two cross-validation studies tested the predictive validity of the scale in a short-term follow up sample of treated sex offenders and a long-term follow-up sample of untreated sex offenders. The samples predominantly – although not exclusively – comprised sexual offenders against children. The ROC Area under the Curve was 0.77 and 0.75 for the two samples. The two and 16 year follow up recidivism rates were 0.9% and 8% low risk, 1.3% and 18.3% medium risk, 5.7% and 40.5% high risk, and 17.2% and 60% very high risk, respectively.

Similarly, Static 99 (Hanson and Thornton 2000), used widely in Canada and the United States, contains ten items concerned with four broad categories associated with increased likelihood of committing further sexual offences. Although slightly more complex than the Risk Matrix 2000, it can also easily be compiled from file information. Static 99 was validated on four diverse samples comprising both child molesters and rapists, with follow

up periods of between four and 23 years. The average ROC Area under the Curve for predicting sexual recidivism was .71 (and .69 for violent recidivism). Sexual recidivism rates for five and 15 year follow up periods were 6% and 7% low risk, 12% and 19% medium-low risk, 33% and 40% medium-high risk, and 39% and 52% high risk, respectively.

Outcome data was collected in a variety of ways. Reconviction data was available from the Home Office Criminal Index, and corroborated from probation and forensic mental health files. Probation files also contained data on breach and recall decisions in relation to sexual offenders who had not re-offended, but were taken back to court or into custody as a result of inappropriate behaviour or non compliance with statutory or treatment expectations. Thus *failure* in the community was subdivided into sexual, violent, or general re-convictions, and breach. Close collaborative working relationships between probation, social services and forensic mental health, led to additional information being available regarding *sexually risky behaviours (SRB)*. This variable was intended to capture behaviours which might reasonably be thought of as sexual offending or 'approach' behaviours that were close to sexual offending, and included:

- Sexual re-convictions, arrests and charges for sexual offences
- Violent re-convictions with a clear sexual element
- Breach for high risk behaviours (for example, individuals observed to be following potential victims, entering households against advice where potential victims were available, or heavy drinking which was previously associated with sexual offending)
- Child protection investigations in relation to new allegations or concerns, regardless of

the outcome

Unfortunately, the sensitivity in relation to police intelligence and data protection meant that permission was refused to access police intelligence which was not already known to probation and forensic mental health services.

Time at risk was calculated in months, from the time of conviction (if in the community) or the time of release from custody, to the time of failure or to the survival cut off point of January 2002.

The data was coded and analysed, where appropriate, using the SPSS statistical package. The area under the Receiver Operating Characteristics (ROC) curve was used as a measure of predictive accuracy. This can range from 0.50 to 1.0, with 1.0 indicating perfect prediction and 0.5 indicating prediction no better than chance. The area under the ROC can be interpreted as the probability that a randomly selected recidivist would have a more deviant score than a randomly selected non-recidivist. The area under the ROC has the advantage over other commonly used measures of predictive accuracy that it is not constrained by base rates or selection ratios (Thornton et al. 2002).

Results

The total sample comprised 310 subjects (80 rapists and 230 child molesters). Risk Matrix 2000 and Static 99 scores were available for 235 subjects (62 rapists and 173 child molesters). There were 273 subjects at risk in the community (64 rapists and 209 child molesters).

a) Measures of risk

Table 3.1 shows the risk status for child molesters and rapists and any significant differences between them. As can be seen, there was a spread of risk levels, although significantly more low risk child molesters than rapists. Differences between the Risk Matrix 2000 and Static 99 were not marked, although there was a slight tendency for the Static 99 to rate offenders at a higher risk level.

Table 3.1

Risk status		*Rapists*		*Child molesters*		*Significant differences*
Risk Matrix 2000:	low	62	17 (27)	173	87 (50)	X2 26.474,df 3,p.01
	Medium		19 (31)		57 (33)	
	High		26 (42)		23 (13)	
	Very high		0		6 (4)	
Static 99:	low	62	8 (13)	174	77 (44)	X2 23.056,df 3,p.01
	Medium-low		32 (52)		65 (37)	
	Medium-high		16 (26)		21 (12)	
	High		6 (10)		11 (6)	

Risk status for child molesters and rapists

Table 3.2

Variable	*Child molesters*		*Rapists*		*All sex offenders*	
	N	*% (range low-v.high)*	*N*	*% (range low-v.high)*	*N*	*% (range low-v.high)*
Background/developmental variables						
Sexually victimised as a child	139	38-100**			181	33-100**
2+ childhood difficulties	139	42-100**			175	40-100**
Sex play with other boys as a child	121	15-100**			154	13-100**
Contact with mental health services	149	14-67**			199	14-67*
History of self harm	150	13-50*			196	11-50*
Adult homosexual contacts	135	13-83**			177	11-83**
Offence-related variables						
Victim sex : male	172	17-83**			232	16-83*
Female		79-17				81-17
Physical coercion during offence	151	19-50*			209	26-50*
Bribes used during offence	149	35-67			201	30-67*
Location of offence : victim's house	158	67-33**	59	35-4*	209	64-33**
outside		10-67		59-96		19-67
Admitted to deviant fantasies during offence	121	31-100*			158	28-100**
Failure in the community						
Failed	167	6-50**			222	6-50**
Type of failure : sexual re-offence	167	1-17**			221	1-17**
Violent re-offence		1-4				1-2
General re-offence		1-13				2-13
Breach/recall		2-33				2-33
Survived		94-50				94-50

p<.05 , ** p<.01

Risk Matrix 2000 and its association to other variables

Table 3.2 outlines those background and offending characteristics – not covered in the scales themselves – which were significantly associated with higher risk levels in the Risk Matrix 2000. The significant findings for Static 99 were similar, and are therefore not reported in detail. Higher risk in child molesters was clearly associated with a range of childhood and adult difficulties, and some offence-related variables such as the use of physical coercion and offending outside the victim or perpetrator's home. Indications of possible psychosexual difficulties – sexual victimisation, sex play with boys, male victims and admitting to deviant fantasies, were also associated with risk in child molesters. There was only one significant finding with respect to rapists – high risk rapists were more likely to offend outside the home.

b) Formal failures

Overall, there were 37 (13%) failures in the community, of which 28 (13%) were child molesters and 9 (13%) were rapists. Nine (2%) subjects were re-convicted for sexual offences – 6 (3%) child molesters and 3 (5%) rapists - and 4 (1%) were re-convicted for violent offences overall. Although both Risk Matrix 2000 and Static 99 were significantly associated with failure (see Table 3.2), sexual re-convictions were spread across all risk levels, with the greatest proportion (50%) falling into the medium risk category for Risk Matrix 2000, and 66% falling into the medium-low and medium-high Static 99 categories. This was similar in the case of violent re-convictions, where 50% fell into the Risk Matrix 2000 medium risk level, and 100% fell in the Static 99 medium-low range.

Table 3.3 outlines the variables associated with failure in the community for child molesters and rapists. For child molesters, and the overall sample, failure was significantly associated with previous sexual, violent and un-convicted sexual allegations, as well as use of alcohol and drugs during the offending period. Sexual victimisation in childhood was associated with failure in child molesters, but physical victimisation and childhood difficulties were associated with failure in rapists.

Table 3.3

Variables	*Child molesters (%)*			*Rapists (%)*			*All sex offenders (%)*		
	N	*Failed*	*Survived*	*N*	*Failed*	*Survived*	*N*	*Failed*	*Survived*
Background/developmental variables									
Sexually victimised in childhood	181	19(76)**	75 (48)				218	21 (64)	76(41)*
Someone else sexually victimised in family	124	8(50)**	11(10)				157	9 (41)	12 (9)**
Physically abused in childhood				48	6 (75)	8 (20)**	233	16 (49)	56(28)*
Witnessed physical abuse				39	6 (75)	7 (23)**	181	14 (54)	43(28)**
2+ childhood difficulties				36	6 (75)	9 (32)*	208	25 (74)	88(51)*
History of self harm							230	9 (26)	21(11)*
No cohabiting (1 year +) adult relationships	191	11(46)*	44(86)				241	17 (53)	63(30)**
Offence-related variables									
History of un-convicted allegations	184	9(45)*	38(23)				226	11 (41)	42(21)*
Previous convictions:	208						259		
None		3(11)**	82(45)					6 (17)	100(45)**
Sexual		12(44)	41(23)					15 (42)	46(21)
Violent		8(30)	14 (8)					10 (28)	22(10)
Both sexual and violent		0	7 (4)					0	10(5)
General offences		4(15)	37(20)					5 (14)	45(20)
Physical coercion during the offence	186	11(42)*	36(23)				239	17 (47)	65(32)*
Substance misuse during offence:	198						246		
None		10(8)*	117(68)					13 (39)	133(62)*
Alcohol		8 (32)	39 (23)					11 (33)	56(26)
Drugs		1(4)	5(3)					2 (6)	6(3)
Alcohol and drugs		6(24)	12(7)					7 (21)	18(8)

Variables associated with failure in the community

Table 3.4

	Child molesters N=217 (%)		*Rapists N=67 (%)*		*All subjects N=284 (%)*		*Total*		
	treated	***untreated***	***treated***	***untreated***	***treated***	***untreated***	***CM***	***Rapists***	***All***
Average months at risk (sd)	61(36)	48(32)**	37(22)	35(16)	57(35)	44(29)**	55(35)	36(19)	51(33)**
Risk status:									
RM high/v.high	19 (21)	10 (12)	9 (43)	17 (42)	28 (26)	27 (22)			
Static medhigh/high	22 (25)	10 (12)*	6 (27)	16 (39)	28 (26)	26 (21)			
Survived	97	92	19	39	116	131	161(85)	58(87)	247(87)
Failed :									
• *Sexual offence*	4	2	2	1	6	3	6(3)	3(5)	9(2)
• *Violent offence*	1	2	1	0	2	2	3(1)	1(2)	4(1)
• *General offence*	5	3	2	2	7	5	8(4)	4(6)	12(4)
• *Breached/recalled*	8	3	1	0	9	3	11(5)	1(2)	12(4)
Total Failures	18 (16)	10(10)	6(24)*	3(7)	24(17)*	13(9)	28(13)	9(13)	37(13)

significant at the p.05 level; ** <0.01

Failure in the community

c) Community treatment and failure

Table 3.4 outlines the detailed break down of failures, for type of failure and whether or not the child molesters and rapists were in community treatment.

Initially it appeared that treated rapists, and treated subjects overall, were more likely to fail than untreated subjects. However, time at risk in the community was greater for the treated sample and for child molesters, and risk levels were also higher for child molesters. The treated group were also more likely to have been sexually victimised (X2=4.162,df 1,p.05), physically abused (X2=3.224,df 1,p.05) and emotionally abused (X2=5.804,df 1,p.01). When re-analysed, controlling for risk levels and childhood abuse, no significant differences were found between failure rates in treated and untreated subjects. The treatment variable was re-coded, to explore the failure rate for the structured group program only, in comparison with all other subjects. Although risk levels were now similar between the groups (suggesting that slightly more high risk subjects were placed in individual treatment), there were no significant differences in failure.

d) Sexually risky behaviours as failures

Sexually risky behaviours (SRBs) were analysed in a similar fashion. Overall, there were 27 subjects who failed due to SRBs, 6 (8%) rapists, and 21 (10%) child molesters. Aside from those who were re-convicted, two additional subjects were arrested, one of whom was subsequently acquitted in court. Variables significantly associated with SRBs are shown in Table 3.5.

Those in the structured group treatment program were significantly more likely to show SRBs than those in individual treatment or no treatment. However, once again, when risk levels, and childhood difficulties were controlled for, there were no significant differences in SRBs between treated and untreated subjects. Indeed, there was a non-significant trend for higher risk subjects in any community treatment to fail by means of SRBs less often (10%) than those in no treatment (22%); whilst 14% of those in group treatment failed compared to 25% of all other subjects.

Table 3.5

Variables	***Sexually Risky Behaviour N=27 (5)***
Background/developmental variables	
Physically abused in childhood	16 (64)**
Sexually victimised in childhood	17 (68)*
Attended special schooling	6 (23)*
No long term (1 year +) relationships	11 (46)*
Offence related variables	
History of un-convicted allegations	9 (43)*
Index offence type:	
• Child molesters	21 (10)
• Rapists	6 (8)
Verbal threats during the offence	13 (50)**
Status in the community	
Risk Matrix 2000	
• Low/medium	12 (7)*
• High/very high	9 (17)
Static 99	
• Low/medium low	11 (6)*
• Medium high/high	10 (20)
Average time at risk	
Treatment status	
• Group program	12 (15)*
• Support or no treatment	15 (7)

Variables significantly associated with 'Sexually Risky Behaviours' (SRB)

e) Predicting risk with both offence and developmental variables

The area under the ROC curve was calculated in a number of ways, in order to determine whether the Risk Matrix 2000 or Static 99 could reliably predict failure or SRBs in the community, and whether any key background variables might augment the accuracy of prediction. Table 3.6 shows the ROC areas, and those which are .700 and above, are highlighted.

Table 3.6

Offence type	*Predictor*	*Any failure (ROC)*	*Sexually risky behaviour (ROC)*
Child molester	Risk Matrix 2000	**.713**	.648
	Static 99	**.768**	.663
	Static 99 + sexual victimisation	**.785**	.683
Rapist	Risk Matrix 2000	.667	**.711**
	Static 99	.530	**.711**
	2 childhood difficulties + physical abuse	**.815**	**.811**
	Static 99 + 2 childhood difficulties + physical abuse	**.717**	**.851**
All subjects	Risk Matrix 2000	**.700**	.651
	Static 99	**.713**	.659
	Static 99 – 2 childhood difficulties + physical abuse	**.733**	.697

Actuarial and developmental predictors of failure

In summary, both actuarial tools were reasonably predictive of formal failure in all subjects, and specifically in child molesters, although less so for SRBs. Overall, Static 99 performed better than Risk Matrix 2000. When background/developmental variables were added, the sample sizes diminished, and therefore results should be interpreted with

caution. However, a composite score for Static 99 and sexual victimisation in childhood was highly predictive of failure in child molesters. A composite score for Static 99, two or more childhood difficulties and physical victimisation in childhood was predictive of both formal failure and SRBs in rapists, and of formal failure (but not SRBs) in all subjects.

Discussion

The lack of sampling bias in the research design means that data on almost all convicted sex offenders in S.E. London over a seven year period are included in this research. The advantage over other validation studies (Hanson and Thornton 2000) is that this sample is not restricted to incarcerated or treated offenders, but should reflect the full range of child molesters and rapists in an urban area. As a result, it may be that there is a slightly higher proportion of less serious sex offenders serving community sentences. Some of the analyses have, however, been hampered by a degree of missing data in relation to background characteristics, and low recidivism rates. As sexual reconviction data clearly under-represents the offending rate, the development of SRBs as an outcome variable has attempted to address this shortfall. Given the contained geographical area, and the relationships which exist between services, this is likely to be a reasonably accurate reflection of observed risky behaviours. Clearly, some behaviours will go unobserved, and some subjects in the community for long periods of time will be lost to services. It should be remembered, that only a small proportion of SRBs resulted even in an arrest; many were for behaviours that did not involve an offence. However, it is reasonable to assume that a number of potential offences were prevented because of the stringent

supervision and liaison arrangements which have been in place over the past three years. Such arrangements include the Sex Offenders Register (Sex Offenders Act: Home Office,1997) and the development of multi-agency public protection panels (MAPPPs: Home Office, Criminal Justice and Court Services Act 2000).

The research findings would lend support for the use of either the Risk Matrix 2000 or the Static 99, both of which were able to predict failure in the community for child molesters and rapists. There was slightly stronger support for the predictive accuracy of the Static 99, but this was not marked. The tools were less effective in predicting sexual recidivism. This may be because high risk offenders are unusually closely supervised, or because they are more motivated to refrain from offending as they fear a discretionary life sentence as a result. Whatever the reason, 19 of 20 subjects rated high or very high on the Risk Matrix 2000 apparently survived in the community. Given an adequately long follow up period – over four years – this is encouraging, although it would be expected for this survival rate to continue to fall over time. Sexual recidivism was more likely to occur in those rated as medium risk, and in some ways, this group may prove to be more problematic to manage in the community. Beech, Friendship, Erikson and Hanson (2002) and Thornton (2002) found that combining the Static 99 with deviancy levels – determined by psychometric results – markedly enhanced the prediction of risk in this group.

Overall, the reconviction rate was very low, less than that suggested by Hanson and Bussière (1998), and in line with Friendship and Thornton's (2001) findings.

Professionals may be reassured by the low general failure rate in the community, and the

capacity of supervisory agencies to monitor offenders and take early action. Needless to say, small numbers render reliable statistical analysis uncertain, and many of the findings should be interpreted cautiously.

Sexually risky behaviours appeared to be a valid attempt to address the constant criticism that reconviction rates never represent the true offending rate in sex offenders. Although imperfect, the sexual failure rate was raised 200% by this method, and a similar range of background and offence-related factors were associated with SRBs. It should be emphasised that only two additional recorded offences were included in this sample which did not result in a conviction. The remainder of SRBs related to concerning behaviours where offences may or may not have been about to occur. This approach may well have captured elements of Hanson and Harris' (2000) acute dynamic variables, particularly increased substance misuse, lowered compliance with supervision, and opportunities for victim access.

Both the risk tools, and failure, were associated with a range of background and offence-related variables. The links were stronger for child molesters than for rapists. The offence-related variables were in line with previous research, and suggested the importance of a level of violence in the offence. As before, certain offence variables were conspicuous by their absence, for example, levels of denial. The role of developmental experiences was particularly striking. In line with previously reported findings (Craissati and Beech 2001; Craissati et al. 2002), childhood difficulties and trauma, and to a lesser extent, psychological difficulties in adulthood, were relevant to failure. Access to this

information was largely due to assessments conducted by mental health professionals, whilst criminal justice files were limited to detailed offence analysis. The results would suggest that sex offenders with a range of psychological difficulties may be at higher risk for failure in the community.

This research highlights the difficulty in determining whether or not treatment contributes towards risk management in the community. Without a meaningful control group, serious distortions in the results can occur. In this sample, some of the sex offenders who entered the group treatment program had refused to do so in prison; others did not received community treatment having made significant improvements in prison programs. Those entering individual treatment may have done so because of short periods of statutory supervision and low motivation, or may have been thought too disruptive or disturbed for the group program. The results would suggest that the community program is targeting appropriate offenders for a treatment program which is a partnership between probation and forensic mental health services; that is, targeting high risk offenders with a range of associated psychological difficulties. The trend towards those in group treatment failing less often than others is encouraging, given that they presented with many characteristics associated with failure. Indeed, the profile of the offenders in community treatment would have been predictive of higher levels of failure than in fact occurred.

There was cautious support for the predictive validity of the current tools based on static factors. However, a significantly improved model involved a composite score of Static 99 and childhood difficulties and trauma. The differences between child molesters and

rapists – encountered elsewhere in the research – would suggest that the best risk tools may need to be tailored to different types of sex offender. For example, sexual victimisation in childhood may be more salient to child molesters, whilst physical victimisation in childhood may predict failure more reliably in rapists.

Future directions clearly need to aim to replicate the prediction models described in this research, with larger sample sizes and in different settings. There is strong evidence for the salience of background and psychological difficulties in a risk management model; criminal justice assessments, with their emphasis on offence-specific factors, may be missing key indicators of potential community failure. It is not yet clear to what extent the findings of this research overlap with the dynamic assessment models currently under evaluation, and/or whether they accurately reflect pervasive personality dysfunction in line with a diagnosis of personality.

Key points

Even with larger sample sizes and a longer follow up period, the research continues to point to the relatively low sexual reconviction rate for child molesters and rapists. With the introduction of 'sexually risky behaviours' as an outcome variable, the research has been able to capture behaviour of concern, particularly that which leads to community failure. There is growing evidence for the importance of key developmental variables in contributing to a risk prediction model.

CHAPTER FOUR

A REVIEW OF DYNAMIC VARIABLES AND THEIR RELATIONSHIP TO RISK PREDICTION IN SEX OFFENDERS

The key literature on risk prediction in sex offenders – which is largely offence focused - makes little or no reference to developmental variables, and yet Chapter three confirms the importance of childhood disturbance and trauma contributing independently to a consideration of risk, but in particular, to a more general failure in the community. Childhood developmental experiences are likely to influence adult functioning – at an emotional, cognitive and interpersonal level – and therefore may play a role in determining dynamic risk variables in relation to sexual offending. Furthermore, the use of 'sexually risky behaviours' in Chapter three identified a group of offenders who were returned to prison, or caused concern, on the basis of behaviour which appeared to represent a precursor to re-offending. Clearly some offenders may be determined to re-offend despite the consequences, but others may resort to risky behaviour in the face of stress and interpersonal difficulties. Again, the relationship between managing life in the community, and adverse developmental experiences needs to be explored.

This chapter provides a literature review of the recent work on dynamic variables relevant to sex offenders, and their relationship to risk prediction models. Enduring psychological functioning is explored as well as acute and immediate mental states.

Particular attention is paid to the relationship between dynamic domains – identified in the literature – and apparently fixed developmental variables, such as attachment and victimisation experiences.

A REVIEW OF DYNAMIC VARIABLES AND THEIR RELATIONSHIP TO RISK PREDICTION IN SEX OFFENDERS.

Abstract

In recent years, a good deal of attention has been paid to the question of recidivism in sex offenders, with an emphasis on the pool of identified static variables associated with risk. The paper aims to review the developing evidence-base for dynamic – changeable – variables, describing their clinical and research characteristics. It also considers the relationship between dynamic domains and apparently fixed developmental variables, such as attachment and victimisation experiences. Three main models are presented, and examined in terms of their ability to enhance static prediction models. Results would suggest that there are four dynamic domains which can predict sexual recidivism, independently of static risk prediction, and that these domains should be of central consideration in the continuing development of treatment programmes.

Introduction

The use of actuarially based risk prediction tools for sex offenders has now become standard practice in Britain. The impetus for this has been advances in the academic literature formalising risk prediction (for example, Hanson & Bussiere, 1998; Hanson & Thornton, 1999) and developments in practice, as exemplified by the establishment of Multi-Agency Public Protection Panels in each area of England and Wales. Until

recently, the emphasis has been on the development of valid tools based on static (fixed or historical) variables which are easily accessible from file data, and can be reliably applied across areas and agencies. Although statistically robust, such tools (Static99, Risk Matrix 2000, Hanson & Thornton, 1999) have two obvious limitations. A classification of risk – associated with a probability of sexual reconviction – does not assist practitioners in determining whether an individual offender is likely to fall into the re-offending category associated with his level of risk. The second difficulty is developing a risk management strategy which might target potential for change, that is, opportunities to reduce the risk that individual offenders might pose.

In comparison to static/fixed variables, there has been some difficulty in establishing empirical evidence to support the relevance of many dynamic (changeable) factors to risk prediction in sex offenders. The most widely known model for combining static and dynamic variables has been the HCR-20 (Douglas, Cox & Webster, 1999) which provides a framework for organising judgment about the risk posed by mentally disordered offenders. Until recently, work on sex offenders specifically was largely focussed on the role of deviant sexual interests, including the physiological measurement of arousal. More recently, work in Canada (Hanson & Harris, 1998, 2000, and 2001) and in England and Wales (Beckett, Beech, Fisher & Fordham, 1994; Beech, Friendship, Erikson & Hanson, 2002; Thornton, 2002) has begun to establish meaningful relationships between a cluster of dynamic variables and sex offender recidivism. The identified variables are summarised in Table 4.1, and discussed in more detail later in this section.

Dynamic variables are those characteristics of sex offenders which are capable of changing. The most useful, of course, are those that are amenable to deliberate intervention. Hanson & Harris (1998) suggest that dynamic variables can be further divided into *stable* dynamic risk factors, which would be expected to persist for months or years, and *acute* dynamic risk factors, which may last for days or only minutes.

The theoretical model underpinning this work is based on social cognitive theory (see Craissati, 1998, for a brief outline of the theory). Schemas are stable cognitive patterns which develop in early life as part of normal cognitive development, and are shaped by events and relationships; underlying assumptions are conditional beliefs based on schemas; automatic thoughts are the cognitions that automatically and temporarily flow through one's mind and will often reflect persistent cognitive distortions. The model, in relation to sex offenders, can be understood as "Recidivistic sexual offenders would be expected to hold deviant schema, or habitual patterns of thought and action, that facilitate their offences. The likelihood that an offender will invoke such schema would increase if the schema were well rehearsed, were triggered by common circumstances, were considered socially acceptable, and were consistent with the offender's personality and values." (Hanson & Harris, 2000, p2)

Stable dynamic variables

Hanson & Harris' work relates to both child molesters and rapists, although they have excluded incest offenders from their analysis. They identified groups of recidivists and non-recidivists, matched on key static variables, examined the offenders' files and then

interviewed their supervising officers in the community using a structured interview schedule. The defining characteristic of this design lay in their emphasis on *observable* dynamic variables, although this method could also lead to problems with reliability if other researchers try to replicate their work.

The best three stable predictor variables from the officer interview strongly differentiated the recidivists from the non-recidivists were:

- sees self as no risk
- poor social influences
- sexual entitlement

It should be noted that the differences were generally much stronger in rapists and child molesters with male victims, and not so strong for child molesters with girl victims. From this the Sex Offender Need Assessment Rating (SONAR) was developed in an attempt to find a standardised method for measuring change in risk levels over time. The SONAR was based on the five dynamic categories outlined in Table 4.1, with the addition of four acute factors. Scores can range from 0 to 14. Overall the scale showed adequate internal consistency and moderate ability to differentiate between recidivists and non-recidivists (r=.43; ROC area of .74[1]), even when well-established static risk indicators were controlled for.

---

[1] ROC refers to the Receiver Operating Characteristic, which plots the hits (true positives) and the false alarms (false positives) at each level of the risk scale; the area under the ROC curve can range from .50 – prediction no better than chance – to 1.0 perfect prediction (Hanson & Thornton, 1999)

Table 4.1

Hanson & Harris (1998 & 2000)	*Beech (1998 & 2000)*	*Thornton (2001*
Intimacy deficits ▪ "grave difficulty in establishing meaningful relationships with adult women" ▪ poor empathy ▪ numerous, uncommitted relationships	**Social competency** ▪ Self-esteem ▪ Emotional loneliness ▪ Under assertiveness ▪ Personal distress (general empathy) ▪ Locus of control	**Socio-affective functioning** ▪ Self-esteem ▪ Emotional loneliness ▪ Emotional congruence ▪ Rehearsal of negative emotions ▪ Rumination of anger
▪ **Social influences** ▪ Negative peer associates ▪ Peers supporting denial ▪ Peers facilitating victim access ▪ Peers with anti-social attitudes		
Attitudes ▪ Little remorse or victim empathy ▪ Sexualisation of children ▪ Sexual entitlement ▪ Anti-social attitudes	**Pro-offending attitudes** ▪ Cognitive distortions ▪ Victim empathy distortions ▪ Emotional identification with child	**Distorted attitudes** ▪ Rape myths ▪ Justifications for sex with children
Sexual self-regulation ▪ Frequenting prostitutes ▪ Strong sexual urges, frustration if not gratified ▪ Sexual activity increases social status ▪ Sexual activity mitigates life stress ▪ Negative affect leads to sexual imagery		***Sexual interests***
General self-regulation ▪ Impulsivity ▪ Lifestyle instability, unemployment, substance misuse ▪ Compliance with supervision/treatment ▪ Self as low risk, no avoidance of high risk situations		***Self management*** ▪ Benign control ▪ Aggression control

Dynamic factors related to risk

Revisions to the SONAR model are ongoing, and up to date information – including an expanded and detailed scoring system – can be obtained from Hanson & Harris (email: dsp-psd@sgc.gc.ca).

In England and Wales, the development of sex offender treatment programmes has been underpinned by systematic evaluation over the past eight years by the STEP team evaluation (Beckett et al, 1994; Beech, Fisher & Beckett, 1999; Beech 1998). This work has focussed on child molesters, who have engaged in community probation treatment programmes, residential programmes and prison programmes for sex offenders. They established that child molesters could be divided into "high deviancy" and "low deviancy" groups on the basis of their deviation on psychometric measures from non-offending norms. The psychometrics were selected in order to assess pro-offending attitudes and levels of social competency. Specifically, high deviancy means that the dynamic risk factors underlying offending are relatively intense and pervasive. Such offenders perceive children as:

- sexually sophisticated
- sexually pro-active with adults
- unharmed by such contact and are able to consent to it;

Such offenders

- have a variety of problems dealing with adults and initiating or maintaining intimate relationships with other adults;

- are generally underassertive, with low levels of self-esteem,
- cannot cope with stressful interpersonal situations and see themselves as having little control over their lives.

Low deviancy refers to dynamic risk factors that are relatively weak in intensity and circumscribed in their effect. These offenders do not have globalised cognitive distortions about children, or low levels of social competence. Beech (1998) determined deviancy level from psychometric measures, by using cluster analysis techniques. As might be expected, they found that high deviancy men were typically sexual recidivists who had either committed extra-familial offences against boys, crossed over between male and female victims or between victims in intra- and extra-familial situations. However, it is important to note that about 25% of incest perpetrators were assessed as high deviancy. In a six year follow up study of sex offenders receiving community treatment, Beech et al (2002) found that pretreatment deviancy levels increased the predictive power of Static 99 by between 25-86% in terms of reconviction rates (see Table 4.2). Pretreatment deviancy levels were also crucial in determining the number of treatment hours required to produce treatment change: 78% of low deviancy men showed significant improvements in pro-offending attitudes when given more than 80 hours of group treatment compared to only 20% of high deviancy men. Twice as many hours of treatment (160 plus) were necessary to effect change in pro-offending attitudes for high deviancy men, 60% of whom demonstrated a treatment effect.

Although the sample size is relatively small, the results would suggest in particular, that identifying high deviancy sex offenders who would otherwise be considered low or

medium risk on static tools, would greatly assist risk assessment. The strength of this approach is the use of standardised measures which can easily be replicated. However, psychometrics require a level of training and knowledge that may not be accessible to all practitioners in the field. To this end, the STEP researchers provide regular training in the UK for the psychometric evaluation of sex offenders. There is now an algorithm, based on the results of the measures, with a cumulative scoring procedure which allocates individual offenders to a high or low deviancy category: emotional congruence with children, cognitive distortions regarding children and under-assertiveness are the three most heavily weighted variables.

Table 4.2

	High deviance	Low deviance	Total sample
Total sample	7/23 (31%)	1/30 (3%)	8/53 (15%)
High Static	2/4 (50%)	0/1 (0%)	2/5 (40%)
Medium-high Static	4/9 (44%)	0/4 (0%)	4/13 (31%)
Medium-low Static	0/2 (0%)	0/6 (0%)	0/8 (0%)
Low Static	1/8 (13%)	1/19 (5%)	2/27 (7%)

Six year follow-up reconviction rates by Static 99 and pretreatment deviancy level (Beech et al, 1998)

Thornton's (2002) work on an Initial Deviance Assessment (IDA) contains four domains of dynamic variables, as shown in Table 1, which overlap with the approach adopted by Hanson & Harris (2000) and Beech (1998). Thornton defines deviancy in terms of the extent to which the offender's functioning is dominated by the psychological factors that

contribute to his offending, by means of psychometric measures (akin to Beech,1998). He postulates that the main dynamic risk factors fall into four domains:

- Sexual interests
- Distorted attitudes
- Socio-affective functioning
- Self-management

The IDA has three deviancy levels – high, moderate and low. High deviance is defined as an individual showing problems within at least two domains; moderate deviance is when marked dynamic risk factors are present in just one domain; and low deviance is when no marked dynamic risk factors are apparent. The IDA model was tested on a group of 158 child molesters currently serving a prison sentence and undergoing assessment. The sample was broken into two groups: first time sexual offenders, and recidivist sexual offenders. The repeaters group tended to score in a more dysfunctional way on all five indicators of social-affective functioning, to demonstrate worse self-management on both indications, and to score higher on all measures of distorted attitudes. The IDA was subsequently cross-validated on a sample of 117 adult male sex offenders – including both child molesters and rapists - who were assessed in prison for the sex offender treatment programme, and who had been at risk in the community for an average of three years. Psychometric measures were available for all subjects, across three of the four domains; no measures for the Sexual Interests domain were available. The IDA showed reasonably good ability to differentiate between recidivists and non-recidivists (ROC 0.78). The Static 99 was also completed on the sample, and was strongly related to sexual recidivism

(ROC .92). Both Static 99 and IDA independently predicted sexual reconviction, and combined, led to an improved model (see Table 4.3).

Table 4.3

	High deviancy	Medium deviancy	Low deviancy
IDA alone	5 of 34 (15%)	2 of 43 (5%)	0 of 40 (0%)
High Static	4 of 6 (67%)	1 of 5 (20%)	0 of 2 (0%)
Medium-high Static	1 of 12 (8%)	1 of 12 (8%)	0 of 5 (0%)
Medium-low Static	0	0	0
Low Static	0	0	0

Reconviction rates by Static 99 and Initial Deviance Assessment (Thornton, 2001)[2]

Dynamic domains

The cumulative evidence, described above, would lend weight to the consideration of five core dynamic domains which have a growing evidence-base, and which appear to contribute significantly to static risk assessment. The three models utilise different methodologies, but there are no inherent contradictions. The domains are described more fully below.

Intimacy deficits/social competencies

These variables are closely associated with the static variables of never having had a live-in lover, and the victim-perpetrator relationship (acquaintance/stranger). The importance

of intimacy deficits has been widely reported (Marshall, Hudson & Hodkinson, 1993; Ward, Hudson & Marshall, 1996), and are largely manifest by a) an avoidance of adult intimacy in child molesters who fear negative evaluations, or b) rapists who lack empathy for women, have multiple uncommitted sexual encounters, or experience difficulties in managing assertiveness (Overholser & Beck, 1986).

Locus of Control (Nowicki, 1976) measures the extent to which an individual feels that events are contingent upon their own behaviour and the extent to which they feel that events are outside of their control. Child molesters with an external locus of control are less likely to respond to treatment, more likely to have previous sexual convictions, and more likely to re-offend sexually (Fisher, Beech & Browne, 1998). It is not clear how far locus of control is a relevant risk predictor for rapists. Low self-esteem has been found to distinguish child molesters from comparison groups. Emotional loneliness seems to distinguish sexual offenders more generally, and appears to be the only aspect of inadequacy which seems to distinguish rapists (Thornton, 2002). Emotional identification with children should be distinguished from offence victim attitudes, and includes leisure/work activities as well as attitudes which suggest a child-oriented lifestyle.

Stable levels of negative affect - anxious, depressed or angry individuals - does not appear to predict sexual recidivism. It is more likely that it is the way in which offenders cope with negative affect that is relevant to risk. For example, a general tendency to rehearse grievances and to attribute hostility to others may be linked to risk, particularly when directed at women (Hanson & Bussiere, 1998). The experience of negative affect,

---

[2] An average of three years at risk in the community

especially that arising from interpersonal conflict (humiliation and resentment) seems to precipitate offence-related fantasies; child molesters may be especially prone to avoidance-focused coping strategies, and sex may be used as a way of coping with loneliness (Thornton, 2002).

The evidence base for intimacy deficits in sex offenders is confusing, and sometimes apparently contradictory. However, attachment theory provides a unifying model which brings a greater understanding to this area of deficit. In addition to the work on the dynamic domain, there are two static variables – negative relationship with mother as a child (Hanson & Bussiere, 1998; Craissati, McClurg & Browne, 2002b), and single status as an adult (Hanson & Thornton, 1999; Quinsey, Rice & Harris, 1995) – which relate broadly to attachment issues. Sexual victimisation as a child is clinically relevant, but its link to risk prediction has not been established, except intermittently (Craissati, McClurg & Browne, 2002a).

In recent years, attachment experiences in sex offenders have begun to be studied (Marshall, 1993; Hudson & Ward, 1997), usually underpinned by Griffin & Bartholomew's (1994) model of four attachment types. The premise is that erratic and rejecting parenting behaviours, which alienate children from the possibility of forming secure attachment bonds, distinguish the family context in which sex offenders grow up (Marshall, 1989). Low self esteem in sex offenders is the result of poor childhood attachment relationships, and it is this that leaves the adults vulnerable to indirectly seek emotional intimacy through sex, even if they have to force a partner to participate

(Marshall, 1993). Further research by Ward et al (1996) has found rapists to be more likely to be dismissive, and child molesters fearful/preoccupied, in their attachment styles. Smallbone & Dadds (1998) found that sex offenders only differed from property offenders in their maternal attachments which were less secure; specifically, they found intrafamilial child molesters to be more likely to regard their mothers as unloving, inconsistent and abusive; whilst rapists were more likely to regard their fathers as uncaring and abusive to them. Craissati, McClurg & Browne (in press) found that low levels of maternal care were linked to verbal threats to the offence victim for both child molesters and rapists, and there was a link between poor maternal care in child molesters and a history of previous sexual or violent offending.

Social influences

Although the number of criminal companions is one of the strongest predictors of recidivism among the general criminal population, there is limited research on its importance for sex offenders (Hanson & Harris, 2000). There is understandable concern when sex offenders associate with other sex offenders, yet sometimes this is likely to be a response to the ostracisation they otherwise encounter. Nevertheless, Hanson & Harris (2000) found it to contribute significantly to a model of dynamic risk prediction. They suggest identifying all those within an offender's network who are not paid to be with him, and then making a judgement as to whether each person is a positive, neutral or negative influence in the offender's life.

Pro-offending attitudes

The relationship between sexual attitudes supportive of sexual assault – attitudes or values that excuse, permit or condone sexual offending - and sexual offence recidivism seems to be significant, but only to a limited extent (Hanson & Bussiere, 1998). An assessment of pro-offending attitudes, by means of clinical interview, will be heavily influenced by the circumstances in which the offender is being assessed, the degree of shame – rather than distorted belief – that they experience, and the motivational interviewing skills of the assessor (Craissati, 1998). Psychometric measures, as utilised by Beckett et al (1994) and Beech et al (1999) assist in standardising responses. It can be surmised that those who readily endorse obviously distorted views may well pose a high risk of recidivism; it is less likely that those who deny pro-offending attitudes can be reliably classified as recidivists or non-recidivists. Generally, pro-offending attitudes are best viewed as a treatment target, with psychometric measurement providing an essential pre- and post-treatment comparison.

There is likely to be some difficulty in differentiating between child molesters and rapists in terms of pro-offending attitudes. Hanson & Harris (1998) found that there was no significant difference between the two groups in the extent to which they endorsed rape myths or held attitudes which sexualised children . However, they also found that justification for the sex crimes, sexualising children, and feeling entitled to express their strong sexual drive, were all significant in differentiating between recidivists and non-recidivists generally.

There is also a lack of clarity as to whether empathy deficits are general (as measured by the Interpersonal Reactivity Index, Davis 1980; or the PCL-R, Hare, 1991) or specific to a class of potential victims or actual victims, as measured by the Rape Myths Scale (Burt, 1980) or victim empathy distortions (Beckett & Fisher, 1994). Thornton (2002) found that recidivist child molesters showed more distorted attitudes to sex with children and rape myths, suggestive of a more general tendency to distorted attitudes rather than minimisation of a specific kind of offending. Beech et al (1999), in contrast, found that child molesters did not demonstrate general problems in empathy deficits, although cognitive distortions in relation to their own offence victims contributed to a model of high deviancy.

Finally, it should be noted that *denial of offending behaviour* – whether partial or total – has *never* been shown in the research literature to be significantly associated with future sexual re-offending (Hanson & Bussiere, 1998). This is perhaps the most commonly held myth by professionals in the field, and the area of work which is most likely to result in a position of confrontation and stand-off between an offender and the agency/professional. A simple example would be the comparison of an incest offender who remains entrenched in his denial that he ever penetrated his daughter, compared to a persistent child molester with male victims who details his deviant sexual interests whenever asked. The former is likely to be very low risk (depending on his situation) despite the gross injustice of his position in terms of avoiding responsibility; the latter will be high risk despite an open acknowledgement of his offending behaviour.

Sexual self-regulation

There is strong evidence to support the view that sex offenders who present with a poorly controlled expression of sexual impulses are at a higher risk of re-offending. In assessing sexual pre-occupation, it is important to differentiate between the direction (see Deviant Sexual Interests below) and the strength of sexual interests; for example, how frequently the offender engages in sexual activity (not necessarily illegal) such as masturbation, consenting intercourse and frequenting prostitutes. Sexual thoughts/activity may be perceived as intrusive by the offender or interfere with other pro-social goals. High risk sex offenders are more likely to respond sexually to stress or negative affect, or feel deprived/frustrated if they are unable to quickly satisfy their sexual urges (Hanson & Harris, 2000). Clinically, this is often referred to as 'sexualisation', that is, a preoccupation with sex as a necessary and persistent regulator of self esteem (Rosen, 1979), which comforts the individual in the face of anxiety provoking internal conflicts. The degree to which this mechanism pervades the life of an offender (Glasser, 1988) contributes to risk.

General self-regulation

General self-regulation concerns the offender's ability to self-monitor and inhibit antisocial thoughts and behaviours. This cluster of variables – also related to the static variables of violent and general previous offending – incorporates many of the elements of personality disorder and factor two within Hare's psychopathy measure (PCL-R, Hare, 1991). Personality disorder can be defined as conditions which "comprise deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses

to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and particularly relates to others." (International Classification of Diseases, World Health Organisation, 1994, p.200). The anti-social features of a personality disorder may be characterised by attitudes of irresponsibility, a tendency to blame others, low tolerance to frustration, incapacity to maintain enduring relationships, callous unconcern for others or a lack of guilt. Lifestyle impulsivity is not referring primarily to a lack of planning in the index offence, but to a disorganised, irresponsible lifestyle and poor impulse control established prior to adolescence, likely to result in negative consequences. An individual's ability to accurately identify problems, generate potential solutions to problems, and weigh the advantages and disadvantages of important decisions, contributes to their ability to achieve long term goals, or anticipate the consequences of their actions.

Co-operation with supervision – or compliance – warrants separate consideration.

Compliance can be interpreted in several ways:

- poor attendance at supervision or treatment,
- disengagement from or manipulation of supervision/treatment
- being excluded from treatment or dropping out (for whatever reason),
- failure on conditional release;
- adjudications for a range of behaviours whilst incarcerated.

It is worth paying particular attention to attrition in treatment programmes (Craissati & Beech, 2001), as non-compliance has regularly been shown to be related to high

recidivism rates (Marques, 1999; Cook , Fox, Weaver, & Rooth, 1991). Failure to complete treatment – as described above – is *not* the same as failing to meet the treatment goals; a compliant sex offender is one who attends and co-operates with the structure of treatment, regardless of whether that offender has made any demonstrable progress in improving their offence attitudes or social competencies. A difficulty with complying with statutory expectations is likely to relate to psychological difficulties, or personality factors, particularly impulsivity and hostile attitudes.

Deviant sexual interest

Deviant sexual interest can be defined as a distortion in aim (for example, children as victims) or in means (for example, coercion in the 'courtship disorders' of rape). It does *not* just refer to sexual arousal during the course of the offending episode, but should be based on an assessment of *persistent* erotic interests over time.

Hanson & Bussiere (1998) concluded that deviant sexual interest – as measured by the penile plethysmograph (PPG) - was the single most important dynamic factor in predicting sex offender recidivism. These problems can be broken down into the following areas of measurement:

- What is the prevalence of deviant sexual fantasy amongst the general population?
- What is the prevalence of deviant sexual interest amongst sex offender subgroups?
- What proportion of sex offenders with a deviant sexual interest re-offend?
- Does no deviant sexual interest protect against re-offending?

There is research available to support the view that men without sexual convictions may hold deviant sexual fantasies and endorse pro-offending attitudes (Dean & Malamuth, 1997). Laboratory experiments, using phallometry, also found non-offending men to be sexually aroused to depictions of rape (see Murphy, Haynes & Worley, 1991, for a broader review of the literature). It may be that the low reporting and detection rate for sexual offences distorts the link between fantasies and offending, or it may be that deviant sexual arousal alone is insufficient to reduce normal inhibitions to sexual offending. Dean & Malamuth (1997), in their study of students, found that all those who were assessed as high risk for sexual violence against women were likely to imagine aggressing sexually. However, it was only those high risk individuals who were relatively self-centred/dominant (versus those sensitive to others' feelings/nurturant) who were more likely to actually be sexually aggressive. Similarly, Malamuth, Heavey & Linz (1993) found empathy to be a moderator between phallometric assessment of deviant sexual arousal and actual aggression towards women. When empathy was high, there was no relationship between deviant arousal and aggression.

When considering sex offender samples, it has generally been found that only a relatively small proportion of offenders demonstrated deviant sexual arousal. These were generally child molesters with male victims. Marshall (1997) suggests around 25-40% of child molesters fall into this category. Firestone, Bradford, McCoy, Greenberg, Curry & Larose (2000) found that recidivist child molesters showed higher sexual arousal to child assault stimuli (involving coercion) than non-recidivists, as measured by phallometry. However, this was also a significant predictor of general recidivism. Quinsey et al (1995) also found

that deviant sexual interest, as measured by phallometry, was associated with sexual recidivism for both child molesters and rapists, along with previous criminal history and psychopathy.

There is no evidence that the absence of deviant sexual activity reliably predicts non-recidivists. With apparently low or medium risk individuals, other factors seem to be more salient, such as pro-offending attitudes, social competencies and lifestyle impulsivity.

How can deviant sexual interest be measured? The simplest means of assessing this variable, and one often underrated, is simply encouraging the offender to self-report deviant sexual interest. Many offenders with a previous history of sexual convictions, will respond to sensitive exploration of their sexuality, and will acknowledge persistent or sporadic deviant sexual interests. It is, of course, more difficult to ascertain change over time, as the offender is likely to want to reassure the interviewer that his potential risk has reduced. In the absence of self-report, deviant sexual interest in child molesters could be deduced – probably fairly accurately – from static factors, such as victims who are male, or of both sexes, previous sexual convictions, and single status (Hanson, Steffy & Gauthier,1993). The situation is less clear for rapists with a persistent interest in coercive sexual activity. Common sense would dictate that those with previous convictions, probably against strangers, and/or elements of sadism within the offence (see below) are likely to hold persistent deviant interests. Additional elements of any static risk assessment, could useful include personal and social activities of offenders: for example,

child molesters who coach children's football teams, or rapists who work in night clubs or as mini-cab drivers.

The third most prevalent means of ascertaining deviant sexual arousal is the use of phallometry, the penile plethysmograph (PPG). The PPG is a laboratory-based technique for directly measuring penile tumescence in response to a range of auditory and visual stimuli (Murphy et al, 1991). These stimuli usually include photographs of a range of subjects, both male and female, from children to mature adults, and may portray varying degrees of coercion, threat, and seduction. The perpetrator's sexual response is then compared to his reaction to consenting sex between adults. Despite its clinical and research value, it has never been as widely used in Britain as it is in the United States. However, the equipment is expensive, unreliable, and requires skilled administration and considerable expertise in interpreting the results. Langevin (1988) has elaborated on some of the problems associated with interpreting PPG results, including questions regarding the validity of the stimuli, the influence of anxiety and/or prolonged sexual abstinence on arousal and attempts at conscious repression or distortion of arousal. Fisher & Thornton (1993) suggest that the PPG might best be used for determining treatment need, and perhaps in establishing changes in deviant sexual arousal over time, as a consequence of treatment.

Sadism

Sadism as a sexual interest, represents a subgroup of all those sex offenders with persistent deviant sexual arousal. It warrants specific attention because of its link with risk, particularly serious harm, to the victim.

Establishing the prevalence of sadistic sexual interests in offenders is problematic, as it appears to be dependent upon the definition used (see Marshall & Kennedy, 2001, for a summary of the area). MacCullough, Snowdon, Wood and Mills (1983) defined sexual sadism as "the repeated practice of behavior and fantasy which is characterized by a wish to control another person by domination, denigration or inflicting pain for the purpose of producing mental pleasure and sexual arousal (whether or not accompanied by orgasm) in the sadist". A slightly more restricted definition is found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994) which requires evidence for the presence of "recurrent, intense, sexual urges and sexually arousing fantasies, of at least six months' duration, involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting. The person has acted on these urges, or is markedly distressed by them" (p.287). A number of studies (Fedora, Morrison, Fedora, Pascoe and Yendall, 1992) have found that 45% of sexually aggressive offenders fulfilled this criteria for sadism. Studies which rely on police descriptions of damage or mutilation to the victim, or offender self-report, tend to estimate sadism in 5-10% of rapists. This is not greatly different from studies examining sadistic sexual interests in non-offender populations (Freund, Chan and Coulthard, 1979).

Common features found in sexual sadists, which differentiate them from non-sadistic sexual offenders, include a significant history of physical abuse, known cross-dressing, obscene telephone calls and indecent exposure. The offence characteristics of this group include careful planning of the offence, victim taken to a preselected location, intentional torture, victim beaten, forced anal sex and fellatio.

Sadistic sexual killers have been characterised by the long standing nature of their violent fantasies, usually with an onset in adolescence, and containing a ritualised, repetitious core that is highly arousing to the sexual sadist (Warren, Hazelwood & Dietz, 1996). They are highly likely to keep collections of a violent theme, such as videotapes, pictures, bondage material, weaponry, sexually sadistic pornography or detective magazines (Warren et al, 1996). A surprising number may have had no arrest record prior to the murder. The victims tended to be strangers, and the means of killing usually asphyxiation or stabbing – the greater 'intimacy' of the weapon being indicative of the sexual component.

MacCullough et al (1983) commented that the sadistic fantasies tended to be progressive in nature, the sadistic context increasing and fantasy material being based on previous behavioural 'try-outs' of the main fantasy sequence. They suggest that a history of sadistic sexual fantasies, previous tryouts (not necessarily resulting in arrest), and a demonstrable pattern of progression of offending and fantasy, are highly indicative of a probable progression to killing.

Acute risk factors

Acute risk factors are regularly addressed in treatment programmes, particularly those with an emphasis on relapse prevention. However, their evidence-base is much less developed than the work on stable dynamic factors. Acute risk factors are not primarily related to long term risk potential, that is, *whether* an individual will re-offend. Their importance lies in predicting *when* an offender might be likely to re-offend sexually. Therefore, in assessing acute risk factors, the practitioner is interested in deviations from the baseline level of the behaviour for a particular offender, rather than the baseline itself. For example, an offender may be feeling low in mood, but not out of proportion to his current situation; he may hold a generally hostile attitude towards women, but a positive acute risk factor score would relate to an identifiable increase in anger and hostility.

Hanson & Bussiere (1998) found four acute variables which were linked, to some extent, with recidivism, and their utility was reinforced by their contribution to the SONAR (Hanson & Harris, 2000). These are

- Substance abuse
- Negative mood (depression or anxiety)
- Anger/hostility
- Opportunities for victim access

Hanson & Harris (2000) rated these acute factors for the month prior to the assessment, on the basis of no change, improvement or deterioration. Substance misuse problems were defined as interfering in normal daily activities or causing health problems. Negative mood included depressed or anxious feelings, frustration, loneliness or suicidal thoughts. Anger/hostility included volatility, anger towards women and aggressive or threatening

behaviour. Victim access included general opportunities, creating opportunities, computer use and relevant hobbies. All four factors significantly differentiated between recidivists and non-recidivists, although the effect was weakest for negative mood. More recent revisions to the acute risk factor ratings, have added collapse of social supports, an increase in sexual preoccupations, and an increased propensity to reject supervision.

Clearly there may be links between the acute and stable risk factors. Increased substance misuse may relate both to a dysfunctional coping mechanism for managing low mood or anger, and a deliberate attempt to overcome inhibitions to offending. The relevance of mood supports the premise that these offenders sexualise their behaviour in response to uncontained feelings. Opportunities for victim access were not chance events, but a tendency for the offenders to expose themselves to high risk situations, to minimise their relapse potential just prior to re-offending.

Discussion and conclusions

The research on dynamic risk predictors is now sufficiently consistent to support a coherent framework for assessment. Three models have been described which, despite their different methodologies, are fairly consistent in emphasis. All three highlight two domains: pro-offending attitudes and intimacy deficits. The SONAR and IDA also address deviant sexual interests and general self-regulation, although the SONAR is probably the broadest in its scope. Further research and validation of the instruments will undoubtedly lead to adjustments and hopefully, an established track record in enhanced risk prediction.

The question of whether one method is superior to others, very much depends on the circumstances of the assessment and the setting. For example, for those who do not have access to psychometric measures, clinical interview and file information will provide the necessary information, as outlined by the SONAR. Scoring and algorithms provide a valid and reliable approach, allowing comparison pre and post interventions as well as across populations. However, a risk prediction framework may be less concerned with absolute scores than with guidance for good practice in risk management.

The risk management process could be considered to fall into four stages:

1. Initial classification according to static factors
2. Adjustment of the risk classification with regard to the dynamic domains
3. Reference to any unusual or offender-specific factors which have not already been considered (for example, evidence for sadism, or entry into a very high risk situation)
4. Identification and implementation of strategies to target high risk dynamic domains

Stage 4. warrants further consideration. Somewhat regardless of the evidence base, treatment programmes have embraced the model of offence-focused work which targets pro-offending attitudes. To a more limited extent, behavioural treatments have been available to target deviant sexual interest, as has anti-libidinal medication, albeit on the basis of a methodologically poor research base, and with equivocal results. Problems with general self-regulation may indicate the need for supported housing projects, substance misuse programmes, or general thinking skills programmes; such interventions are not just

ways of managing a sex offender in total denial, but may be the primary target for intervention for some types of sex offender. The attention paid to intimacy deficits has been less consistent in treatment programmes, and there has been little consideration of whether interventions, based on skills acquisition, have failed to address underlying attachment problems. This raises the question as to what extent attachment can be changed by experience or treatment. There is some evidence to suggest that the style of treatment delivery influences outcome (Beech & Fordham, 1997), and that attention to issues of self esteem and non-specific factors in individual and group treatment improves interpersonal functioning and empathic responding. Specific attention to attachment experiences, early developmental trauma , and core schema may contribute to improved management of intimacy (Craissati, McClurg & Browne, 2002a; Craissati, McClurg & Browne, 2002b) and an associated reduction in recidivism for high risk offenders.

It is important to note that all the work on dynamic risk predictors in sex offenders relates to adult males. As yet, there are no risk tools for female sex offenders or adolescents, although the research base – particularly for adolescent offenders – is growing. Although common sense would suggest that many of the fixed and dynamic factors will be relevant, the utmost caution should be applied at the current time. Ongoing research will undoubtedly revise and refine these preliminary approaches.

Key points

Early research is encouraging in pointing to the significant contribution provided by dynamic variables in enhancing risk prediction in sex offenders. Three central approaches

undergoing evaluation overlap in their consideration of dynamic domains. There is growing consensus that in addition to pro-offending attitudes, intimacy deficits, sexual and general self-regulation should be considered.

CHAPTER FIVE

ATTRITION IN A COMMUNITY TREATMENT PROGRAMME FOR CHILD SEXUAL ABUSERS

Non-compliance with treatment – or indeed non-compliance with any statutory expectation, such as supervision – was clearly identified in Chapter four as one component of risk in the dynamic domain, general self-regulation. This variable is often overlooked, in the desire to achieve treatment goals, such as a reduction in pro-offending attitudes; that is, an offender's willingness or capacity to complete a period of treatment or supervision regardless of their progress.

Previous chapters have closely examined the prediction of community failure in terms of types of re-offending and risky behaviour. The results suggest that actuarial tools have predictive capacity, but a risk assessment model can be enhanced by consideration of key developmental variables. This chapter focuses on compliance with the community treatment programme, with consideration for both poor attendance (attrition) and drop-out (non-compliance) rates. It examines whether offence-related, or developmental/psychological variables are best able to predict attrition and non-compliance in the sample.

[p85-101]
Beech, AR and Craissati, J (2001)
Attrition in a community treatment program for child sexual abusers. Journal of Interpersonal Violence, 16 (3). pp. 205-221. ISSN 0886-2605

title: Attrition in a community treatment program for child sexual abusers
creator: Beech, AR
creator: Craissati, J
subject: BF Psychology
date: 2001-03
type: Article
type: PeerReviewed

http://dx.doi.org/10.1177/088626001016003002

PAGES NOT SCANNED AT THE
REQUEST OF THE UNIVERSITY

SEE ORIGINAL COPY OF THE THESIS
FOR THIS MATERIAL

Key points

There was very limited evidence to support a relationship between offence-related variables and attrition from treatment or non-compliance, and no evidence to support the relevance of denial. Rather, the strongest predictors of non-compliance and attrition were those variables associated with psychological difficulties or trauma: two or more childhood difficulties and childhood sexual victimisation. These findings provide additional evidence for the role of key developmental variables in enhancing a broad risk prediction model in the community.

CHAPTER SIX

CHARACTERISTICS OF PERPETRATORS OF CHILD SEXUAL ABUSE WHO HAVE BEEN SEXUALLY VCTIMIZED AS CHILDREN

A clear picture is emerging, detailed in the previous chapters, of the importance of childhood experiences of sexual victimisation for sex offenders, particularly child molesters. For example, sexual victimised child molesters appear to pose a greater risk of recidivism and failure in the community, they are more likely to demonstrate sexually risky behaviours, and to miss treatment sessions and/or to withdraw from treatment altogether. There may be many possibilities regarding the potential relationship between sexual victimisation in childhood and later risk posed by sex offenders. One means of gaining a greater understanding of the association is to compare those sex offenders who have been sexually victimised with those who do not report such experiences.

This chapter aims to compare sexually victimised and non-sexually victimised offenders, with a continued focus on child molesters.

[p104-118]

Craissati, J and McClurg, G and Browne, KD (2002)
Characteristics of perpetrators of child sexual abuse who have been sexually victimised as children. Sexual Abuse: A Journal of Research and Treatment, 14(3) (3). p. 225. ISSN 1079-0632

title: Characteristics of perpetrators of child sexual abuse who have been sexually victimised as children
creator: Craissati, J
creator: McClurg, G
creator: Browne, KD
subject: BF Psychology
date: 2002-07
type: Article
type: PeerReviewed

http://dx.doi.org/10.1177/107906320201400303

PAGES NOT SCANNED AT THE
REQUEST OF THE UNIVERSITY

SEE ORIGINAL COPY OF THE THESIS
FOR THIS MATERIAL

Key points

Although the whole sample reported high levels of childhood difficulties and trauma, the sexually victimised perpetrators presented with a number of specific characteristics, in particular, significantly higher levels of psychosexual disturbance. They were also more likely to engage in higher risk offending behaviour such as the choice of male victims. Emotional abuse/neglect as a child, and homosexual contacts as an adult reliably distinguished between sexually victimised and non-sexually victimised perpetrators. It may be that the psychosexual profile of sexually victimised perpetrators reflects something of the 'higher deviancy' categorisation of sex offenders described in Chapter four, and will also have implications for treatment models in terms of content and intensity.

CHAPTER SEVEN

THE CHARACTERISTICS OF A GEOGRAPHICAL SAMPLE OF CONVICTED RAPISTS: SEXUAL VICTIMIZATION AND COMPLIANCE IN COMPARISON TO CHILD MOLESTERS

All too often, research on sex offenders has been criticised for its methodological limitations, particularly the failure to differentiate between types of sex offender (rapists and child molesters, for example), sampling bias and small sample sizes. These problems have hampered our understanding of rapists, resulting in rather inconsistent findings, which may or may not reflect a more heterogeneous profile in rapists.

The aim of Chapter seven is to replicate the work described in Chapters five and six, but with reference to the rapists in the sample, and allowing for comparison with the child molesters. Data on offence variables, childhood victimisation and adult psychological difficulties are described, with a particular focus on comparing sexually victimised and non-sexually victimised rapists. Although the numbers of rapists in the community, and in treatment, are fairly small, preliminary results are reported, in terms of compliance and failure.

THE CHARACTERISTICS OF A GEOGRAPHICAL SAMPLE OF CONVICTED RAPISTS : SEXUAL VICTIMIZATION AND COMPLIANCE IN COMPARISON TO CHILD MOLESTERS

Abstract

The limited research literature which relates specifically to sexual offenders against adults (rapists) would suggest that they are likely to demonstrate a greater criminogenic profile but have experienced fewer childhood and adult psychological difficulties than child molesters. The aim of this study was to describe the characteristics of an urban sample of convicted rapists (n=80), comparing them to a sample of child molesters (n=230) on background and offence-related variables. Although there were a number of similarities between the two groups, rapists were less likely to have been sexually victimised as a child. The sexual recidivism rate was low (5%) for rapists – after an average time at risk of three years - despite a trend towards them being less compliant in the community. The paper comments on the treatment needs of those with a range of psychological difficulties and indicates future directions for research.

Introduction

The expanding academic literature on sex offenders is establishing a growing evidence base for the prediction of risk and the evaluation of treatment efficacy (Hanson et al., 2002). However, it is evident that sexual offenders with adult victims (rapists) have been under-represented in research, and the findings remain rather inconsistent. This may, of course, reflect the potentially heterogeneous nature of rapists (Knight and Prentky, 1990), or may be simply a result of methodological difficulties (see Furby, Weinrott and

Blackshaw, 1989). Specifically, sample sizes of rapists are often small, precluding meaningful statistical findings or subject to skew by a small number of high-risk, highly deviant individuals (Ward, McCormack, Hudson and Polaschek, 1997). Here it is not clear whether this is due to lower rates of convicted rapists compared to child molesters, or whether rapists are more likely to refuse participation in research. Furthermore, sampling bias for sex offenders generally may mean that only those in prison or in specialist hospital treatment settings are recruited for study (for example, Seto and Barbaree, 1999; Prentky et al., 1997). Many studies simply fail to differentiate between subtypes of sex offenders when examining risk predictor variables or treatment outcome (Alexander, 1999). These failings have implications for the development of effective management strategies for rapists who are released into the community.

The research evidence that has compared rapists to other sex offenders (i.e. child molesters) and other types of offender will now be looked at in more detail in terms of the following areas: family background and attachment style, adult characteristics, offence-related factors, and management.

Family background and attachment

It has been consistently noted that the family backgrounds of violent and sex offenders are characterised by neglect, violence and disruption (Bard, Carter, Cerce, Knight, Rosenberg, and Schneider, 1987; Craissati and McClurg, 1996). Dhawan and Marshall (1996) found that both child molesters and rapists reported high levels of sexual victimisation and that this was associated with poor family relations. Higher frequencies and levels of sexual

abuse were found in sex offenders who had begun their sexually coercive behaviour in adolescence rather than as adults, and Knight and Sims-Knight (2002) demonstrated the significance of both sexual abuse and physical/verbal abuse as antecedents in the pathways to sexual coercion against women in both juvenile and adult rapists. Bard et al. (1987), however, found that there were no differences between child molesters and rapists on ratings of physical abuse, or neglect, although child molesters were more likely to have been victims of sexual assaults.

Not only has it been difficult to find clear distinctions in family background between rapists and child molesters, others have found no differences between rapists and violent offenders. For example, Haapasalo and Kankkonen (1997) found that both rapists and violent offenders were comparable in terms of physical and sexual abuse experiences. Again, although there is evidence that rapists have demonstrated more behavioural maladjustment at school than child molesters (Bard et al, 1987), this is comparable to violent offenders (Haapasalo and Kankkonen, 1997).

In terms of attachment style, Ward, Hudson, and Marshall (1996) found rapists more likely to be dismissive, and child molesters fearful/preoccupied, in their attachment styles. Smallbone and Dadds (1998) found that sex offenders only differed from property offenders in their maternal attachments that were less secure. Specifically, they found intra-familial child molesters to be more likely to regard their mothers as unloving, inconsistent and abusive; while rapists were more likely to regard their fathers as uncaring and abusive to them.

Hudson and Ward (1997) summarise the background characteristics of rapists (compared to child molesters) and conclude that rapists differ from child molesters but appear to be similar to the rest of the general prison population.

Adult characteristics

In adulthood, rapists are more likely to have experienced heterosexual relationships (Hudson and Ward, 1997; Quinsey, Rice and Harris, 1995), to be younger, and over-assertive (rather than under-assertive) in comparison to child molesters. They are also more likely to receive a diagnosis of personality disorder (Rice and Harris, 1997; Seghorn, Prentky and Boucher, 1987). Studies do not generally differentiate between types of personality disorder, although it is likely to represent predominantly antisocial types (Hanson and Bussiere, 1998). Related literature on psychopathy in sex offenders – as measured by the Psychopathy Checklist (Hare, 1991) – suggests that rapists are more likely to be psychopathic than child molesters (Rice and Harris, 1997; Seto and Barbaree, 1999). Psychopathic constructs – antisocial behaviour and callousness/unemotionality – are significant components in Knight and Sims-Knight's (2002) model of three pathways to sexual coercion in rapists.

Offence-related factors

Rapists have been found to have a greater number of previous convictions, including violent convictions, but are less likely to have had previous sexual convictions (Rice and Harris, 1997). As might be expected, their sexual offending involves greater levels of

aggression and force than child molesters (Bard et al., 1997). These findings are reflected in the typology of rapists developed by Prentky and Knight (1991), where rapist subtypes are initially differentiated on the basis of the meaning of aggression used in the offence (instrumental versus expressive). Alcohol use associated with the sexual offending has been found in the majority of rapist offences (Hudson and Ward, 1997), but this is also more likely to be the case in terms of illicit drug use, more so than for child molesters (Bard et al, 1997). Establishing deviant sexual interest in rapists has been more problematic and inconsistent than for child molesters (Marshall, Anderson and Fernandez, 1999), although pornography use in rapists is reported less often (Hudson and Ward, 1997).

Management

Reported sexual recidivism rates for rapists are variable, and predictor variables have been difficult to establish (Quinsey, Lalumiere, Rice and Harris, 1995). However, Hanson and Bussiere (1998) found that 18.9% of 1,839 rapists in a meta-analysis sexually re-offended over an average follow up period of four to five years, while 22.1% violently re-offended. The majority of treatment programs have been predominantly designed to meet the needs of child molesters, and rapists are under-represented in treatment studies (Ward et al., 1997). This concern may also be due to rapists being more likely to be in total denial of their sexual offending (Kennedy and Grubin,1992) or to deny the problematic consequences of their own behaviour (Marshall, 1994), more likely to be generally criminogenic and anti-authoritarian, more likely to drop out of treatment, or more likely to re-offend after treatment.

The evidence base for treatability in rapists specifically is limited: Alexander (1999) found little difference in sexual recidivism for treated and untreated rapists (20.1% and 23.7% respectively). While Maletzky (1991) found that 13.8% of rapists were apprehended by police in the follow up period after treatment, as compared to 1.3% of child molesters. However, Marques, Day, Nelson and West (1994) found that 9.1% of their treated rapists sexually re-offended as compared to 27.8% of a volunteer control group of untreated rapists. However, some evidence for the difficulty in engaging rapists in treatment was also found by Marques et al. (1994), where only 15 of the 26 (58%) rapists selected for treatment completed the program compared to 71 of the 106 (67%) child molesters; the ex-treatment group – returned to prison before completing the one year program - re-offended at very high rates, with all eight rapists (100%) sexually re-offending compared to 28.6% of child molesters.

The aim of the present study was to explore the characteristics of convicted rapists in South East London, replicating the published work on child molesters in the same sample (Craissati and Beech, 2001;Craissati, McClurg and Browne, 2002). Specifically, the following will be examined:

To describe the characteristics of a complete urban sample of convicted rapists, comparing them to child molesters on background and offence-related variables. Here it is hypothesised that rapists will report fewer childhood and adult psychological difficulties; Rapists will demonstrate a greater criminogenic profile.

To describe the characteristics of sexually victimised rapists, and compare them to non-sexually victimised rapists; it is hypothesised that sexually victimised rapists will demonstrate a greater level of psychosexual disturbance.

To examine rapists' compliance with a community treatment program; it is hypothesised that rapists will be less compliant than child molesters in treatment; compliance will be predicted by psychological variables rather than offence-related variables.

Method

Subjects

Over a seven year period, 310 subjects were assessed. The sample comprised 80 offenders against adults (rapists) and 230 child molesters, the larger number of child molesters being partly due to the first two years of the program excluding rapists from data collection. The research sample differed from those previously described, in that data were available on all convicted contact sex offenders – child molesters and rapists – resident in two boroughs in South East London.

The conviction data was compiled in collaboration with the local Probation Service. In the majority of cases, the subjects were referred to the Challenge project (a community assessment and treatment program for sex offenders) for psychological reports, prior to sentencing or at the point of release from custody. Forty-four (55%) of the rapists, and 180 (76%) of the child molesters were interviewed. The data on those men not seen were derived from file information and discussion with the respective case (probation) officer. This accounts for some of the missing background data. A small number of offenders (5)

with a primary diagnosis of severe mental illness (usually schizophrenia) were also excluded from the entire analysis.

The results of the Challenge Project – an assessment and treatment program for sex offenders in S.E. London (see below) – have been extensively reported for child molesters, and detailed background and offence-related information is published elsewhere (Craissati and McClurg, 1996, 1997). When sexually victimised child molesters were compared with the non sexually victimised child molesters, it was found that the sexually victimised group were significantly more likely to have experienced a range of childhood abuse and associated difficulties; they were more likely to have a range of psychosexual difficulties; to be recidivists and to offend against boys. Both emotional abuse/physical neglect in childhood, and having homosexual contacts in adulthood significantly contributed to a predictive model (Craissati, McClurg and Browne, 2002a). Sexual victimisation was also found to be significantly associated with community failure (Craissati, Falla, McClurg and Beech, 2002). A comparison of rapists' and child molesters' self report of childhood parenting experiences found that although both groups reported dysfunctional parenting ('affectionless control'), rapists were more likely to report experiences of optimum bonding than child molesters (Craissati, McClurg and Browne, 2002b). Exploration of factors relating to the child molesters' attendance at a community treatment program, and compliance with supervision expectations – attrition – found that variables associated with psychological difficulties and childhood trauma were consistently more important in predicting treatment completion than offence-related variables (Craissati and Beech, 2001).

Procedure

Details of all subjects were obtained from the probation files. Additionally, information was gathered in a semi-structured interview with the offender (or probation officer, if the offender was not seen) which covered personal and social details, a full history of offending behaviour, and monitoring of attitudes towards the offence(s). Witness statements and probation reports were available in all cases, providing a degree of corroborative information on a number of issues relating to the offending. All the background and offending variables were clearly defined and regularly checked by the researchers, particularly if there were doubts about the rating.

A number of variables were considered – on the basis of self report - which are associated with emotional or conduct disorder in childhood. These included ratings (before the age of 16) for persistent truanting or school refusal, significant episodes of being bullied or bullying others, suspension from school for aggression, stealing, running away from home, deliberate self harm, experiencing prolonged difficulties with peer friendships and marked feelings of misery.

Ratings of sexual victimisation were based upon self-report in interview, and corroborative information was sometimes available in previous mental health and probation reports, or the prosecution evidence. Interviewed subjects were asked whether they had experienced unwanted sexual contact under the age of 16 and detail was gathered regarding their early sexual experiences. The issue was approached from a number of

angles: For example, subjects were asked 'tell me about your first sexual experience". "Did you ever get involved in sex play with other boys'. 'Have you ever been touched by someone in a sexual way when you were a child, which made you feel uncomfortable'. Any affirmative or ambiguous answers were followed up. Sexual victimisation was defined as sexual contact with another person that was either unwanted or perpetrated by an adult at least five years older than the subject. Consenting sexual contact with peers was coded separately. Details were gathered on the gender of the abuser, his/her relationship to the victim, the nature of the sexual contact, its duration and whether other members of the family had been sexually abused.

Ratings of physical abuse in childhood were defined as physical contact, perpetrated by an adult on a number of occasions, which was unprovoked, or excessive in relation to any misdemeanour committed by the subject. Ratings of emotional or physical neglect in childhood were defined as persistent and marked failures on behalf of the caring adult(s) to provide adequate and consistent care. Perhaps more than the other categories of abuse, this rating was subject to the opinion of the clinically qualified interviewer

Non-compliance was defined as failure to attend the full treatment program for any reason whatsoever. This included non-attendance (two or more missed treatment sessions), dropping out of treatment prior to completion, removal from treatment due to extenuating circumstances (for example, a deterioration in mental health, or geographical relocation of the client); or subjects who were breached, re-arrested or re-convicted for any reason during the course of treatment, thus failing to comply with the explicit conditions of their

probation order or license on release from custody. Compliance therefore, for the purposes of this study, did not refer to the quality of participation in treatment, or the attainment of treatment goals.

Two actuarially based risk tools were used, and a detailed analysis of risk prediction in the sample is reported elsewhere (Craissati and Beech, 2002). The Risk Matrix 2000 (Thornton, Friendship, Erikson, Mann and Webster, 2002), is used widely in sex offending populations in England and Wales, and can be derived from file information. This comprises a baseline risk classification based on conviction data, adjusted at stage two if two or more aggravating factors are found (for example, male or stranger victims). The two year follow up recidivism rates were 0.9% low risk, 1.3% medium risk, 5.7% high risk, and 17.2% very high risk. Similarly, Static 99 (Hanson and Thornton, 2000), used widely in Canada and the United States, contains ten items concerned with four broad categories associated with increased likelihood of committing further sexual offences. Sexual recidivism rates for five year follow up periods were 6% low risk, 12% medium-low risk, 33% medium-high risk, and 39% high risk.

The risk tools were available from the year 2000, and cases coded retrospectively or prospectively as appropriate. Missing risk assessments (18 rapists and 56 child molesters) were largely due to insufficient available data in old files. Time at risk was calculated in months, from the time of conviction (if in the community) or the time of release from custody, to the time of failure or to the survival cut off point of January 2002.

The data was coded and analysed, where appropriate, using the SPSS statistical package.

Ethical research committee approval was obtained.

Results

Background and offending characteristics

A comparison of rapists and child molesters on background and offence-related variables is shown in Table 7.1. Significant differences are indicated in the following: the rapists were younger and more likely to be single than the child molesters. In terms of background, the two groups were largely similar – both experiencing high levels of developmental difficulties - although child molesters were more likely to have been sexually abused, older at the time of their first sexually intimate relationship, and also more likely to have had a cohabiting relationship (one year or more) in adulthood.

In terms of offending characteristics, the sample appeared to be representative of the full range of sexual convictions, both at the sentencing and at the release stage. As might be expected, the rapists were more likely to have had a female victim in the index offence, to have offended against a stranger, away from the victim's or the perpetrator's home, and for it to have been a one off assault. Rapists were more likely to use verbal threats or physical coercion, and less likely to utilise bribes. They were more likely to have misused alcohol or drugs around the time of the offence. There were differences in levels of denial, rapists being more likely to totally deny their offending behaviour than child molesters, but the two groups were equally likely to fully accept the allegations against them; child molesters were more likely to be in partial denial (in terms of behaviour and/or

responsibility).

In terms of risk prediction tools, rapists were more likely to fall into the higher risk categories than the child molesters, although there were no significant differences in terms of failure rates. Time at risk was 36 months (sd 19) for rapists and 55 months (sd 35) for child molesters. Only 5% of rapists and 3% of child molesters sexually re-offended, and overall 88% of rapists and 87% of child molesters 'survived' in the community.

Variables	Rapists		Child Molesters		Significant differences
	N	Frequency (%)	N	Frequency (%)	
Demographic					
Age	80	Av.32 (sd 10)	230	Av.41 (sd 12)	T 5.493,df 308,p<.01
Marital status: single	80	46 (62)		85 (38)	T 15.270,df 3,p<.01
cohabiting		21 (28)		46 (62)	
Childhood difficulties					
2 + childhood difficulties *	43	19 (44)	184	104 (45)	
parents divorced/separated < age 16	63	27 (43)	208	78 (34)	
sexually abused	52	14 (27)	188	96 (51)	X2-9.366,df 1,p.01
sex play with other boys	38	5 (13)	163	46 (20)	
another family member sexually abused	37	2 (5)	130	20 (9)	
emotionally abused/neglected	56	30 (54)	202	118 (51)	
physically abused	56	18 (32)	201	65 (28)	
witnessed physical abuse	42	13 (31)	154	50 (22)	
literacy difficulties	77	13 (16)	209	41 (20)	
special schooling	66	4 (6)	206	25 (12)	
Adult difficulties					
Adult homosexual contacts	53	9 (17)	185	49 (21)	
Deliberate self harm	56	10 (18)	196	26 (11)	
Contact with mental health services	63	17 (27)	199	49 (21)	
Having had a long term relationship (1 year +)	65	36 (55)	202	146 (72)	X2 6.467,df 1,p.05
Age at first sexually intimate relationship	40	av.16 (sd.2.82)	143	av.19 (sd.5.61)	T 2.798, df,181,p.01
Offending characteristics					
Index convictions: rape/buggery	79	20 (25)	225	48 (21)	
Indecent assault		58 (73)		147 (65)	
Other		1 (1)		30 (13)	
Legal status at referral: remanded	77	47 (61)	222	121 (53)	
Sentenced		22 (29)		76 (33)	
Community sentence		7 (9)		16 (7)	
informal		1 (1)		10 (4)	
Length of custodial sentence (months)	38	av. 42 (sd.34)	80	av. 39 (sd.39)	

informal		1 (1)		10 (4)	
Length of custodial sentence (months)	38	av. 42 (sd.34)	80	av. 39 (sd.39)	
Previous convictions: none	72	22 (31)	220	88 (38)	
Sexual		20 (26)		58 (25)	
Violent		21 (29)		24 (10)	
Sexual and violent		5 (7)		7 (3)	
Other only		14 (19)		43 (19)	
Victim gender: female	76	71 (89)	230	147 (64)	X2 25.109,df 3,p.01
Male		5 (6)		71 (31)	
Both		0		8 (4)	
Number of victims in index conviction: 1 only	77	56 (73)	227	152 (66)	
Relationship to victim: stranger	75	42 (56)	226	22 (10)	X2 80.080,df 2,p.01
Acquaintance		30 (40)		95 (44)	
Relative		3 (4)		97 (45)	
Location of offence: outside	75	53 (71)	207	45 (22)	X2 59.394,df 3,p.01
Duration of offence: one off assault	56	53 (95)	198	75 (38)	X2 59.038,df
Substance use during offending: none	66	27 (41)	206	133 (65)	35,p.01
Alcohol		26 (39)		47 (29)	X2 12.274, df 3,
Drug		5 (8)		7 (3)	p.01
Both		8 (12)		19 (9)	
Acknowledged deviant fantasies during	44	15 (34)	164	75 (33)	
offence	65	30 (46)	193	43 (22)	
Verbal threats	73	48 (66)	197	55 (28)	
Physical coercion	65	4 (6)	194	70 (36)	X2 13.66,df 1,p.01
bribes	77	25 (33)	224	33 (15)	X2 32.313,df 1,p.01
Denial at assessment: total		21 (27)		122 (55)	X2 21.369,df 1,p.01
Partial		31 (40)		69 (31)	X2 25.902,df 4,p.01
Full acceptance					

Risk status					
Risk Matrix 2000: low	62	17 (27)	173	87 (50)	X2 26.474,df 3,p.01
Medium		19 (31)		57 (33)	
High		26 (42)		23 (13)	
Very high		0		6 (4)	
Static 99: low	62	8 (13)	174	77 (44)	X2 23.056,df 3,p.01
Medium-low		32 (52)		65 (37)	
Medium-high		16 (26)		21 (12)	
High		6 (10)		11 (6)	
Failure in the community					
Sexual re-offending	66	3 (5)	217	6 (3)	
Violent re-offending		1 (2)		3 (1)	
General (non S/V) re-offending		4 (6)		8 (4)	
Breach (without re-offending)		0		11 (5)	
Survived		58 (88)		189 (87)	

Table 7.1: Comparison of rapists and child molesters on background and offence-related variables

Sexual victimisation

Of the 80 rapists in the study, data on sexual victimisation in childhood was available for 52 subjects. Of these, 14 (27%) had been sexually abused. Two reported that other family members had also been sexually abused, both by relatives. The average age of onset for abuse was 10 (SD 3.34, range from 6 to 16). Additional data was available for 13 cases. Two were abused by parents, 4 by siblings, 6 by acquaintances, and only 1 by a stranger. Seven men reported being anally raped

The sexually victimised and non-sexually victimised rapists were compared on all variables, and findings with significant differences between the groups are shown in Table 7.2.

Only 3 (8%) subjects of the total sample reported no experiences of sexual, physical or emotional abuse. Clearly, the sexually victimised rapists reported a greater range of childhood difficulties – all reporting having been emotionally abused or neglected - and subsequently, contact with mental health services as an adult. In terms of psychosexual development, sexually victimised rapists were more likely to engage in sex play with other boys as a child, and have adult homosexual contacts. They were more likely to have previous sexual or violent convictions, to engage in penetrative abuse in the offence, and to admit to deviant fantasies at the time of their offending.

Table 7.2

Variables	Non sexually victimised rapists (%) N = 14	Sexually victimised rapists (%) N = 38	Significant differences
Emotionally abused/neglected	16 (43)	12 (92)	X2 9.399, df 1, p.01
Witnessed physical abuse	6 (21)	6 (67)	X2 6.720, df 1, p.05
Another family member sexually abused	0	2 (40)	X2 12.727, df 1, p.05
2+ childhood difficulties	10 (33)	8 (73)	X2 5.072, df 1 p.02
Contact with mental health services as adult	8 (22)	7 (54)	X2 4.757, df 1, p.05
Sex play with other boys	1 (3)	4 (57)	X2 13.593, df 1, p.01
Adult homosexual contacts	1 (3)	7 (64)	X2 20.946, df 1, p.01
Previous convictions:			
None	14 (42)	1 (8)	X2 13.652, df 4, p.01
Sexual	6 (18)	6 (46)	
Violent	3 (9)	5 (39)	
Other	7 (21)	0	
Sexual and violent	3 (9)	1 (8)	
Penetrative abuse in offence	1 (13)	3 (75)	X2 4.688, df 1, 0.05
Deviant fantasies admitted	7 (24)	7 (70)	X2 6.797, df 1, p.05

Characteristics of sexually victimised rapists

Table 7.3

Variables	Rapists		Child Molesters		Significant differences
	N	Frequency (%)	N	Frequency (%)	
Treatment issues					
Previous treatment: none	75	55 (73)	226	110 (49)	X2 22.825,df 2,p.01
Individual		5 (7)		79 (35)	
Group		15 (20)		37 (16)	
Research status: group treatment	74	12 (16)	217	60 (28)	X2 17.480,df 4,p.01
Individual (manual)		2 (3)		27 (12)	
Individual (supportive)		5 (7)		22 (10)	
Relapse prevention only		6 (8)		5 (2)	
No treatment		49 (66)		103 (48)	
Attendance at treatment: full attendance	23	7 (30)	100	38 (38)	
1 missed session		5 (22)		23 (23)	
2 + missed		11 (48)		39 (39)	
Non compliant during treatment	23	13 (57)	106	44 (42)	

Treatment issues

Attendance and compliance in treatment

Rapists were more likely to have had no previous treatment, and were less likely to participate in community treatment with the Challenge Project (see Table 7.3). Of those who did attend community treatment, almost half missed two or more sessions, while 57% were rated as non compliant overall. However, the rapist sample's attendance and compliance was not significantly different from that of child molesters, despite a trend towards greater non compliance.

Given the small number of rapists in community treatment, it was not possible to undertake a meaningful statistical analysis of those variables predicting non compliance or missed treatment sessions. There was some suggestion that those who demonstrated physical coercion in the index offence were more likely to be rated as non compliant during treatment (77%), but this was not replicated in terms of attendance.

Discussion

This paper has aimed to present a stratified geographical sample of convicted rapists, minimising the potential skew of sampling bias in previous studies. In doing so, we have been able to compare convicted rapists to child molesters in this area. It is acknowledged that the urban location may limit the generalisability of the results.

Despite generally high levels of reported childhood and adult difficulties, rapists were – as hypothesised – less likely to have been sexually victimised than child molesters. Their relative youth in commencing sexually intimate relationships might suggest that they were

more confident or more interested in romantic attachments than the child molesters. It may also be that the sample of child molesters represents a broader spectrum of offenders than research samples based in specialist treatment settings or prisons. However, substance misuse was more prevalent in the offences of rapists. There were also specific offence details which differed, as might be expected: rapists were more likely to assault women, outside of either the offender's or the victim's home; the offence was a one off assault against a stranger, associated with verbal threats and physical force to subdue the victim.

Arguably, the similarities between rapists and child molesters were more striking than their differences. There was no clear evidence to suggest that the rapists presented with a greater criminogenic profile than the child molesters. In both samples, 25% had previous sexual convictions while 33% had no previous convictions.

Although rapists were less likely to have been sexually victimised, those that had been, demonstrated a greater level of psychosexual disturbance than those who had not been sexually victimised. This profile was very similar to that found in the child molesters (Craissati, McClurg and Browne, 2002), and would suggest that sexual victimisation has a universal impact on sex offenders regardless of offense type. There was some suggestion that sexual victimisation may be associated with greater risk of recidivism and reported deviant fantasies. It is likely that such rapists have treatment needs – associated with childhood trauma – which cannot be fully met by current program content, and a history

of contact with mental health services would support the need for a multi-agency or multi-modal approach to treatment.

There was also a trend for rapists to be less compliant than child molesters, in terms of attendance in treatment and compliance overall. However, the analysis was hampered by the small numbers of rapists in the community treatment program. Given that half the rapists were generally compliant – and the sexual recidivism rate remained low – there was no evidence to support the view that rapists cannot be managed in the community. Establishing a predictive model for understanding the risks associated with community treatment would be helpful. Despite relatively small numbers, the lack of clear associations with non compliance – unlike the sample of child molesters (Craissati and Beech, 2001) – may be an indication that rapists form a genuinely more heterogeneous subgroup of sex offenders.

There have been limitations: first, the almost inevitable absence of un-convicted rapists in the sample, who are likely to comprise up to 90% of all assaults against adult women (Harris and Grace, 1999). Second, although offending information for the rapists was almost complete, such offenders were more likely than child molesters to be sentenced without psychological reports, or to fail to co-operate with probation/psychology interviews, leading to a certain amount of missing data on background information. Nevertheless, there is no evidence to suggest that uncooperative rapists are likely to have a different profile from those clinically interviewed, and the results are therefore likely to be fairly representative of convicted sex offenders. The sample clearly comprised rapists

across the spectrum of risk, both at the sentencing and the release stage of their conviction.

This preliminary research has highlighted a number of future directions. Clearly, the research needs to continue to increase the sample size, especially those in community treatment. The descriptive data would be usefully augmented with information on cognitive and affective functioning in rapists, in terms of a psychometric profile of dynamic factors; this is currently underway, and will complement work currently being undertaken by the STEP team on the prison population. Finally, the role of risk related variables and developmental variables in predicting community failure has not been addressed in this paper, and is the subject of another study (Craissati and Beech,2002).

Key points

In the comparison between rapists and child molesters, there were more similarities than differences to be found. Although fewer rapists reported being sexually victimised as a child, the victimised rapists presented with a similar level of psychosexual disturbance to the child molesters, as reported in Chapter six. The trend for rapists to be less compliant in community treatment and supervision needs to be viewed with caution, given the relatively small sample size.

CHAPTER EIGHT

THE PARENTAL BONDING EXPERIENCES OF SEX OFFENDERS: A COMPARISON BETWEEN CHILD MOLESTERS AND RAPISTS

The preceding chapters have gathered evidence for the significance of key developmental variables in contributing to a prediction of risk and non-compliance in the community. The incidence of childhood experiences of abuse and neglect has been high, and childhood disturbances – emotional and behavioural indicators of psychological distress – have also been linked to community failure. Research and clinical experience would suggest that these factors are not independent, but rather inter-linked. That is, victimisation in childhood is likely to result in childhood disturbance, and those children who are emotionally and behaviourally disturbed are likely to be vulnerable targets for abuse. It has been postulated that one contributory factor which renders a child vulnerable to abuse and distress is his/her early experience of attachment to a primary carer.

This chapter aims to explore early attachment experiences, and to determine whether adverse or insecure attachments are associated with the key developmental variables identified in earlier chapters. This chapter also moves away from a reliance on self-report in interview, administering a psychometric measure – the Parental Bonding Instrument – to both child molesters and rapists with the aim of measuring and comparing perceived parenting styles. The Addendum to the chapter presents the results of an additional small study, which aimed to establish meaningful comparison groups – violent (non-sexual) offenders and a locally recruited control group of non-offenders.

[p145-157]

Craissati, J and McClurg, G and Browne, KD (2002)
The parental bonding experiences of sex offenders: a comparison between child molesters and rapists. Child Abuse and Neglect, 26(9) (9). 909-922. ISSN 0145-2134

title: The parental bonding experiences of sex offenders: a comparison between child molesters and rapists
creator: Craissati, J
creator: McClurg, G
creator: Browne, KD
subject: BF Psychology
date: 2002-09
type: Article
type: PeerReviewed

http://dx.doi.org/10.1016/S0145-2134(02)00361-7

PAGES NOT SCANNED AT THE
REQUEST OF THE UNIVERSITY

SEE ORIGINAL COPY OF THE THESIS
FOR THIS MATERIAL

ADDENDUM TO CHAPTER EIGHT

THE PARENTAL BONDING EXPERIENCES OF SEX OFFENDERS: A COMPARISON STUDY WITH LOCALLY RECRUITED VIOLENT OFFENDERS AND CONTROLS

The aim of this further study was to recruit two additional groups - one of which would act as a control group - in order to provide locally relevant comparison data on the PBI. It was hypothesised that

1. The control group would report fairly optimum bonding experiences
2. The violent offender group would report dysfunctional parental bonding experiences, but similar to the rapists
3. The child molesters would report the most dysfunctional parental bonding experiences

Method

The child molester and rapist groups are fully described in main body of the chapter. The violent offender group comprised men referred to forensic psychologists for assessment or treatment in relation to their violent offending. All the offences involved significant interpersonal violence, either domestic or against strangers and acquaintances. The control group comprised nurses and probation trainees resident and working in the area. The nurses were spread across all grades, both qualified and unqualified; the probation trainees were from a spread of educational and social backgrounds.

Background information was available for the violent offenders, in terms of comparing reported childhood experiences. The control sample provided their age, but it was felt to be unduly sensitive to ask for information on key developmental experiences and a barrier to participation in the study. The PBI was completed for both mother and father (or equivalent parental figures) when appropriate.

Results

There was a significant difference in the average age of the subjects in each group: child molesters were the eldest with an average age of 41.61 (sd 11.18), compared to the average age of the violent offenders which was 34.26 (sd 8.65). Rapists and the control group were aged 35.05 and 36.04 respectively.

As can be seen from Table 8.4, there were significant differences in the extent to which the groups reported developmental difficulties: child molesters were significantly more likely to have been emotionally abused than violent offenders, whilst there was a trend for rapists to report more emotional abuse than violent offenders, but less than child molesters. This was also true of reported sexual victimisation in childhood. There was a trend for experiences of physical abuse to have been almost twice as common in violent offenders than in the sex offenders, but this was not statistically significant. Of those subjects who had been physically abused, 75% of violent offenders said this was perpetrated by their father, compared to 55% of child molesters and 38% of rapists. In terms of the overall sample of offenders, being emotionally, physically or sexually abused were all significantly associated with high levels of weak bonding and affectionless

Table 8.4

Developmental experience	*Child molester (%) N=54*	*Rapist (%) N=21*	*Violent (%) N=20*	*Significant differences*
Emotionally abused	35 (65)	10 (48)	7 (35)	X2=5.788,df 2,.05
Sexually abused	29 (54)	5 (24)	2 (11)	X2=13.490,df 2,.00
Physically abused	20 (36)	8 (38)	12 (63)	

Background information across the three offender groups

Table 8.5

	Child molesters N=57		*Rapists N=21*		*Violent offenders N=23*		*Controls N=28*	
Mean scores PBI								
Mother care *	20.16 (sd 10.46)		23.24 (sd 10.92)		21.78 (sd 10.22)		22.37 (sd 10.35)	
Mother protection	15.63 (sd 8.02)		14.37 (sd 5.05)		14.61 (sd 8.04)		12.64 (sd 6.95)	
Father care	16.75 (sd 10.55)		20.19 (sd 8.95)		15.15 (sd 10.60)		19.22 (sd 9.35)	
Father protection	14.69 (sd 6.65)		14.44 (sd 6.78)		17.00 (sd 9.06)		12.33 (sd 7.11)	
PBI matrix category	*Mother*	*Father*	*Mother*	*Father*	*Mother*	*Father*	*Mother*	*Father*
Optimum bonding	12 (21%)	9 (18%)	8 (40%)	6 (35%)	7 (30%)	5 (25%)	15 (54%)	9 (33%)
Weak bonding	13 (23%)	12 (24%)	3 (15%)	1 (6%)	3 (13%)	1 (5%)	3 (11%)	9 (33%)
Affectionate constraint	7 (12%)	8 (16%)	4 (20%)	4 (24%)	4 (17%)	2 (10%)	4 (14%)	6 (22%)
Affectionless control	25 (44%)	22 (43%)	5 (25%)	6 (35%)	9 (39%)	12 (60%)	6 (21%)	10 (37%)

* significant at $p<.05$

Parental Bonding Instrument Scores across the four groups

control in mothers ($p<.01$). However, this was not clearly the case for fathers, where no significant associations were found.

In terms of the PBI, there was only one significant difference in average scores across the four groups (Table 8.5): child molesters were more likely to rate their mothers as low in care, compared to the rapists who rated their mother's care highly. The trend for paternal care was for child molesters to rate it best, with the violent offenders rating it lowest. Maternal overprotection was highest in child molesters and lowest in the control group, whilst paternal overprotection – again lowest in the control group – was highest in the violent offenders.

In terms of PBI matrix categories (Table 8.5), there were no significant differences between groups. The control group rated their fathers fairly equally across the four domains, although in more than 50% of cases, they rated their mothers as providing optimal bonding. The violent offenders rated both their parents most frequently as providing affectionless control, but this was particularly striking in the case of their fathers (60%). Rapists were almost as likely to rate their parents as providing optimum bonding as the control group – particularly for their mothers - although affectionless control also featured. Child molesters were most likely to rate both their parents as providing affectionless control.

control also featured. Child molesters were most likely to rate both their parents as providing affectionless control.

Discussion

The results provide the first data set with the PBI being used to compare sexual and violent offenders with a control group, in terms of self reported recollections of their experience of the parental relationship as a child.

Unfortunately, there was a lack of significant differences between groups overall. This may have been due to the relatively small sample sizes for all but the child molester group, as there were trends in the expected direction. It may also reflect limitations to the psychometric properties of the questionnaire. Rather contrary to expectation, the control group reported a range of parental bonding experiences – characterised by relatively high levels of parental care and low levels of parental overprotection – but where only their mothers were most likely to be rated as providing optimal bonding overall. This may reflect the particular characteristics of a control group comprising those in the helping profession, either in terms of their developmental experiences or in terms of the way in which they might reflect on such experiences.

It was clear that the violent offenders tended to rate dysfunctional bonding in their fathers, both in terms of low care, high overprotection, and affectionless control overall. This was

consistent with the finding, from clinical interview, that almost twice as many violent offenders as sex offenders had been physically abused, almost always by their fathers.

Whilst child molesters were more consistent in their ratings of dysfunctional parental bonding experiences, there were only significant differences, in relation to the other groups, in terms of mother's care. This was, however, consistent with the finding, from clinical interview, that they were the group most likely to have been emotionally and sexually abused.

The results of the rapists on the PBI were the most inconsistent with the research literature regarding attachment difficulties, and the finding, from clinical interview, in terms of their experiences of being abused in childhood. Furthermore, they did not present as similar a profile to violent offenders as might have been expected. They were the group most likely to report high levels of care – greater even than the controls - and low levels of overprotection. Again, they rated as many parents as providing optimal bonding as the control group. This would provide tentative support for the assertion that rapists are most likely to deny, dismiss, or idealise difficulties in their primary relationships.

Future directions will need to include the gathering of larger sample sizes, particularly of rapists, violent offenders and controls. The PBI may need to be complimented by other measures of primary attachment and romantic relationships. Finally, the PBI may have a

useful role in treatment, in terms of aiding a focus on relationship difficulties, highlighting patterns of dysfunction in an offender's life and exposing inconsistencies of view.

CHAPTER NINE

CONCLUSIONS AND FUTURE DIRECTIONS

Aim

The aim of this thesis has been to establish the extent to which developmental variables may contribute to a risk assessment model in sex offenders. Particular attention has been paid to broad questions of management in the community, examining compliance with treatment, and failure for a variety of reasons.

Total sample

The final sample comprised 310 subjects, but sample sizes vary across the studies according to the focus of the study. Table 9.1 outlines the basic subject numbers on key baseline variables.

Table 9.1

	All subjects	***Rapists***	***Child molesters***
Total data set	310	80 (26%)	230 (74%)
At risk (average 4 years)	273	64 (23%)	209 (77%)
Actuarial scores	235	62 (26%)	173 (74%)
Community treatment	139 (48%)	25 (34%)	114 (52%)
Formal failures	37 (13%)	9 (13%)	28 (13%)
Sexual re-convictions	9 (2%)	3 (5%)	6 (3%)
'Sexually risky' behaviours	27 (10%)	6 (8%)	21 (10%)

Sample sizes for baseline variables in the thesis

Summary of findings

A number of significant findings are reported. Chapter two is a preliminary study of the first 178 child molesters. The risk assessment tool (SACJ-min, Grubin, 1998) was a precursor to the Risk Matrix 2000, and showed that there was an appropriate spread of risk levels in the sample. However, with a low base rate of reconviction - 1.3% (two subjects) after an average of three years at risk - it was clear that a larger sample size, with a longer period of time at risk, would be necessary for more detailed analyses.

Chapter three revisited the question of actuarial risk prediction, with a larger sample size, a longer period at risk in the community, and the sample contained rapists as well as child molesters. Both the Risk Matrix 2000 and the Static 99 were able to predict general failure, and sexual recidivism, and higher risk status was associated with a range of background and offence-related variables. The failure rate continued to be very low, despite the longer period of time at risk, and even with the inclusion of a broader category of 'sexually risky' behaviours (incorporating the sexual recidivists). Although the two actuarial tools performed similarly, the enhanced risk prediction model was better with Static 99: a composite score for Static 99 and sexual victimisation in childhood was highly predictive of failure in child molesters, whilst a composite score for Static 99, two or more childhood difficulties and physical victimisation in childhood was predictive of both formal failure and SRBs in rapists, and of formal failure (but not SRBs) in all subjects.

Having accrued evidence for the efficacy of validated risk prediction tools, and the potential contribution of key developmental variables to risk assessment – both of which are based on fixed or historical factors – Chapter four reviewed the current literature on dynamic variables which had been examined in relation to risk. Although the methodology and terminology differed between researchers, it was clear that there was growing agreement about the key areas to consider in terms of dynamic risk prediction. Dynamic domains included intimacy deficits, pro-offending attitudes, sexual self-regulation (including deviant sexual interests) and general self-regulation. Hanson and Harris (2001) suggest the additional category of social influences, and also introduced acute (in contrast to stable) dynamic variables which focus on *when*, rather than *whether* a sex offender might re-offend, the so called "panic-now" factors.

One important aspect of managing risk in the community, is determining the likelihood with which a sex offender will comply with treatment expectations, particularly regarding regular attendance and completion of the programme. This is because treatment attrition is associated with significantly raised sexual recidivism risk (Marques, 1999). In Chapter five, which only looked at child molesters, a number of predictive models were examined in relation to attrition and non-compliance. It was found that:

- having two or more childhood difficulties and never having cohabited were able to correctly classify 87% of poor attenders;
- *not* having been sexually victimised as a child and *not* having had two or more childhood difficulties correctly classified 77.5% of compliers;
- childhood difficulties and contact with adult mental health services correctly classified 83.3% of non-compliers.

Thus difficulties in ensuring that child molesters completed a community treatment programme could be predicted by key developmental and psychological variables, rather than offence-related variables.

Chapter six examined the question of sexual victimisation in childhood in great detail. Forty-six percent of the child molesters reported being sexually victimised, and they differed from the non-sexually victimised group in many respects. As might be expected, the sexually victimised group experienced a broad range of associated childhood trauma and difficulties, they reported a greater number of psychosexual difficulties, higher levels of deviant offence-related attitudes on psychometric measures, and tended to offend against boys. Both emotional abuse in childhood and having had adult homosexual contacts were able to reliably distinguish between sexually victimised and non-sexually victimised child molesters.

Although rapists – as reported in Chapter seven – were less likely to report sexual victimisation, they did experience a range of developmental difficulties; furthermore, the sexually victimised rapists demonstrated a similar profile of psychosexual disturbance to the sexually victimised child molesters.

Exploring the question of compliance and attrition in rapists – as described in Chapter seven – was restricted by smaller sample size, and rapists were less likely to enter community treatment. However, although 57% of rapists were rated as non-compliant overall, attendance and programme completion was not significantly lower than for child molesters.

Chapter eight measured perceived parenting styles in both child molesters and rapists, comparing them to violent offenders and a locally recruited control group of non-offenders. Child molesters were more consistent in their ratings of dysfunctional parenting experiences, particularly in relation to their mothers, and this was in keeping with reported childhood abuse. The rapists presented a mixed picture, similar in some ways to the control group, with relatively high levels of reported optimal bonding, inconsistent with reported childhood abuse. This latter finding would suggest that rapists are more likely to deny childhood difficulties or idealise experiences of parenting.

Proposed model

In conclusion the thesis has been able to demonstrate clearly that developmental variables can play an important role in risk assessment, and that such variables are also implicated in the successful maintenance of sex offenders in a community treatment programme. Figure 9.1 shows diagrammatically how key developmental variables can enhance the risk assessment process, by contributing directly to a static measure, and indirectly to stable and acute dynamic considerations. An adjusted final risk assessment, can then allow for different levels of community intervention. These key developmental variables include *childhood experiences of abuse and neglect (sexual, physical and emotional), childhood emotional/behavioural difficulties, and insecure attachments to primary caregivers.*

It should be remembered that this is not a causal model, describing the pathways to sexual offending, but simply a risk prediction model, aimed at differentiating those sex offenders at highest risk of community failure from those most likely to succeed.

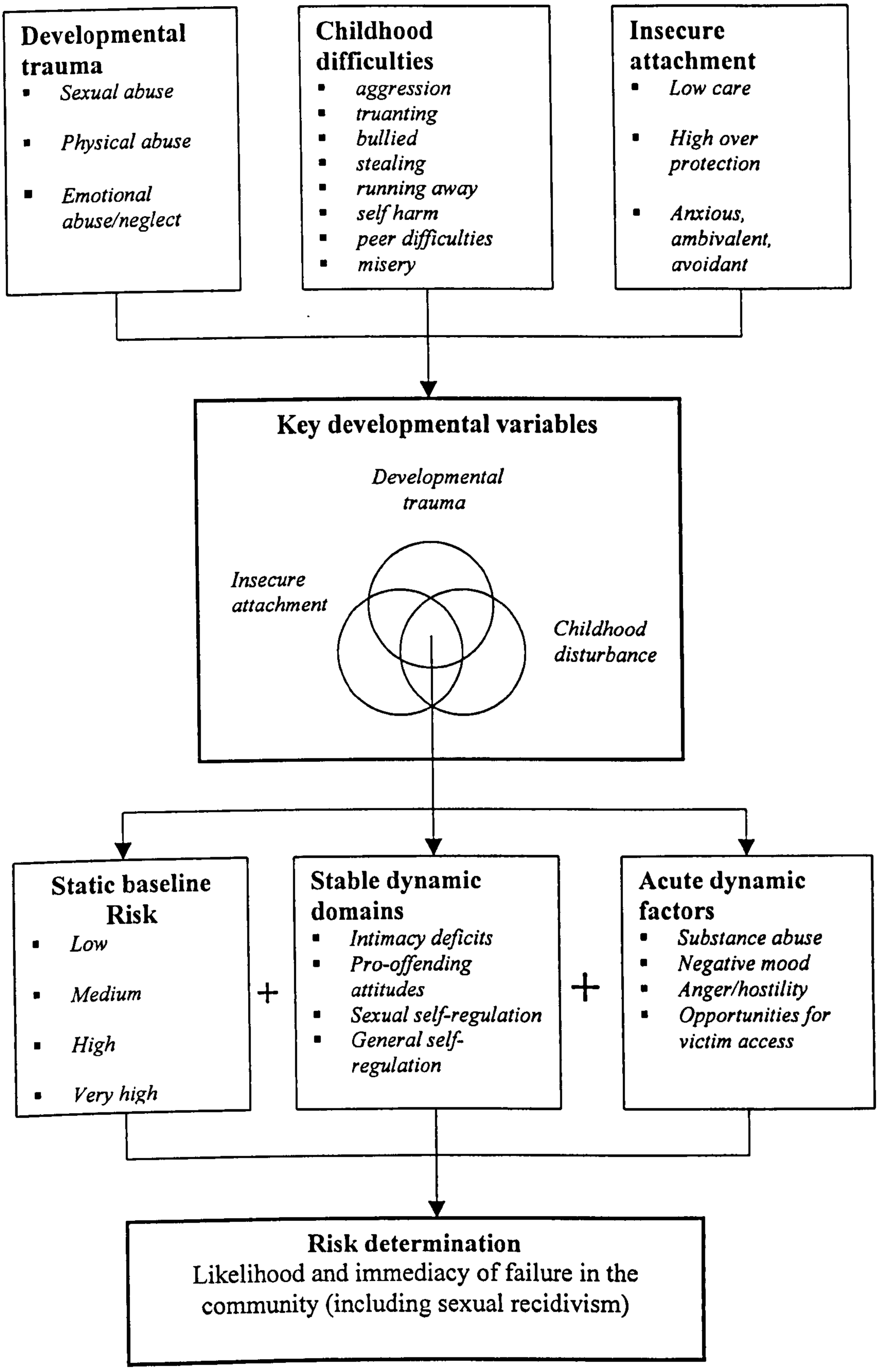
Nevertheless, it is likely that these key developmental variables are highly relevant – but probably not sufficient – to explain pathways to offending. The relationship between the three types of developmental difficulty is likely to be interdependent to some extent. However, not all sex offenders who have been sexually abused have insecure attachments to primary caregivers; similarly, an offender may have been insecurely attached, but may not have manifested behavioural difficulties in childhood, or been sexually abused. The model postulates that a combination of two or three of the key areas in an offender's background – considered in conjunction with a static risk prediction level – is the key to determining risk of community failure.

These developmental variables are technically fixed or historical variables. The literature on static risk prediction could be criticised for its exclusive preoccupation with offence-specific variables, albeit relatively easily determined from criminal justice files. This highlights the potential risks in separating risk prediction models from a wider consideration of psychological factors implicated in sexual offending. As clearly stated by Grubin and Wingate (1996), it is important not to lose sight of the clinical meaning which underpins static and dynamic variables in risk prediction. It is likely that both static and dynamic variables are capturing similar underlying clinical/psychological issues. For example, more than one sexual appearance, male victims, and single status, are likely to indicate a deviant sexual interest in children (Hanson & Harris, 1998); several criminal appearances and single status may well indicate sex offenders with marked problems in general self-regulation (such as antisocial and impulsive features). In a similar fashion, experiences of sexual victimisation in childhood, in the context of an absence of normal affectionate nurturing experiences, may well lead an offender to experience difficulties in sexual

self-regulation, resorting to sexual imagery and activity to regulate affect. This is also likely to influence entrenched attitudes in terms of the enduring sexualisation of children. Furthermore, a history of developmental trauma and difficulty may result in adults who are vulnerable, in terms of their capacity to cope with stress; acute dynamic factors – particularly substance misuse and affective instability/hostility –may be raised, with an associated increase in the risk of community failure.

It is therefore reasonable to conclude that, in the same way as dynamic variables can enhance static risk prediction models (Beech et al., 2002), developmental variables are also able to make a significant contribution to static prediction.

Fig. 9.1



A risk prediction model, with key developmental variables

These findings have implications for treatment. Developmental difficulties clearly suggest that an individual may find it difficult to complete a community treatment programme. It may be that he has a greater level of social or psychological need which requires additional resources, and partnerships may have to be formed between health and criminal justice agencies, in order to provide optimum care. Standard treatment programmes may need to be adjusted to address a wider range of psychological difficulties. This is based on the premiss that although developmental variables are fixed, their impact on an individual's psychological functioning in adulthood can be moderated. Such treatment adjustments may need to focus on content relevant to childhood experiences, and/or on group processes. The group can be a validating environment in which individual trauma is heard, shared, believed, and made sense of within the context of offending behaviour. Alternative models could consider other forms of psychological treatment to be run in parallel with offence-focussed programmes, or consecutively. At present, there does not appear to be an evidence-base which indicates a preferred model of care. There is certainly no evidence-base to suggest that developmental trauma should be addressed as an *alternative* to offence-focussed cognitive behavioural approaches. That is, addressing developmental trauma is *not sufficient* in itself, but is likely to be a necessary *component* of an overall treatment and management approach in those sex offenders at high risk of community failure.

Ways forward

There are methodological limitations to this study, not least the smaller sample size of rapists. The urban nature of the sample may also limit its applicability to more rural settings, although in other ways, the sampling method has considerable strengths in

terms of a representative profile of all convicted sex offenders. The outcome variables have been carefully described throughout the chapters, and 'Failure' broken down into sexual, violent, and other/general recidivism, as well as another formal category of breach or recall proceedings. It is hoped that the new category of 'sexually risky' behaviours goes some way to address the criticism that formal failure is unrepresentative of the true offending figure. However, it does not address the dilemma of risk prediction with un-convicted sex offenders, who probably comprise the greater number of perpetrators.

It would seem important to replicate some of the findings, particularly using a composite score of Static 99 plus key developmental variables to enhance predictive capacity. There is some suggestion that grouping rapists and child molesters together, in terms of risk prediction, may weaken predictive models. This would become clearer with a replication of the enhanced model, particularly with a larger sample of rapists. Aside from the use of the Parental Bonding Instrument, the gathering of information on developmental variables has been based on self-report. This has strengths in terms of the ease with which data can be gathered from interview, but may be subject to reporting biases. Nevertheless, self-report is accessible to a variety of professionals without the need for substantial training or the administration of measures. Whilst this thesis has focused on developmental variables in relation to risk and community failure, there has been no measure of associated psychological disturbance or personality dysfunction in adulthood. Future research should consider the role of these issues: there are a number of measures, including structured interviews and paper and pencil self-report questionnaires, which could provide descriptive and diagnostic information. It could be postulated that there is likely to be considerable overlap

between those identified as higher risk by means of key developmental variables, and those identified as having marked personality dysfunction in adulthood. However, this hypothesis needs to be tested.

APPENDIX I

RESEARCH SCHEDULE

CHALLENGE PROJECT SCHEDULE

DEMOGRAPHIC DATA

NAME..... **SUBJECT NO.....** **Dem01** ☐☐☐

D.O.B.....

DATE REFERRED..... **Date** ☐☐☐☐

DISTRICT:

Greenwich=1; Lewisham=2; Southwark=3; Bexley=4; other =5 **Dem02** ☐

AGE..... **Dem03** ☐☐☐

MARITAL STATUS AT TIME OF OFFENCE..... **Dem04** ☐

married/cohab =1
div/sep =2
single =3
widowed =4

TYPE OF OFFENCE..... **Dem05** ☐

child abuse =1 *indecent calls =5*

exposure (adult)=2 *adult pornography =6*

assault (adult) =3 *child pornography =7*
child and adult =4

EMPLOYMENT HISTORY..... **Dem12** ☐

regular & stable =1
frequently changing =2
often unemployed =3
almost none =4

IN EMPLOYMENT AT TIME OF OFFENCE *(no = 0, yes = 1)*..... **Dem13** ☐

IF SO, FOR HOW MANY YEARS?..... **Dem14** ☐☐

CONTACT WITH PARENTAL FAMILY..... **Dem15** ☐

none =0
some infrequent contact =1
close on going contact =2

CONTACT WITH FRIENDS .... **Dem16** ☐

none =0
some infrequent contact =1
close ongoing contact =2

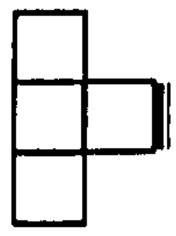
REFERRAL AGENT..... ..... **Dem17** ☐

solicitor =1 *soc.serv =5*
court =2 *child psy =6*
adult psy =3 *other =7*
probation =4

LEGAL STATUS AT TIME OF REFERRAL..... **Dem18** ☐

remand custody =1 *parole =4*
remand bail =2 *informal =5*
sentenced =3 *probation =6*

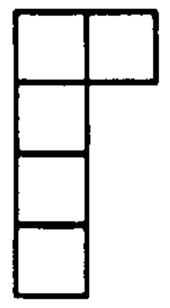
BACKGROUND

PARENTS DIVORCED/ SEPARATED? *(no = 0, yes = 1)*..... **Bac01** 
IF SO, WHAT AGE?..... **Bac02**
EMOTIONALLY/PHYSICALLY NEGLECTED BY PARENTS.....**Bac03**

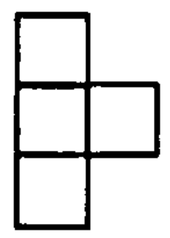
none =0
some =1
a lot =2

PHYSICALLY ABUSED? *(no = 0, yes = 1)*..... **Bac04** 
IF SO, BY WHOM?..... **Bac05**

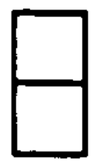
mother =1 *other rel =3*
father =2 *acquaintance =4*

AT WHAT AGE DID IT START?..... **Bac06** 
WITNESSED PHYSICAL ABUSE IN THE FAMILY? *(n = 0, y = 1)* **Bac07**
SEXUALLY ABUSED? *(no = 0, yes = 1)*..... **Bac08**
IF SO BY WHOM?..... **Bac09**

parent =1 *acquaint =4*
stepparent =2 *stranger =5*
sibling =3 *other rel =6*

IF PARENT, WHICH PARENT? *(Father = 1, Mother = 2)*..... **parent** 
AT WHAT AGE DID IT START..... **Bac10**
FORM OF ABUSE:..... **Bac11**

fondled =1 *digital pen =4*
masturbation =2 *buggery =5*
oral sex =3 *gross indec. =6*

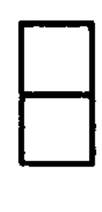
WAS ABUSE PENETRATIVE? *(no = 0, yes = 1)*..... **ownpen** 
WAS ANYONE ELSE IN IMMEDIATE FAMILY
SEXUALLY ABUSED? *(no = 0, yes = 1)*..... **Bac12** 
IF SO BY WHOM?..... **Bac13**

parent =1 *acquaint =4*
stepparent =2 *stranger =5*
sibling =3 *other rel =6*

WHAT FORM DID IT TAKE?..... **Bac14** 

fondled =1 *digital pen =4*
masturbation =2 *buggery =5*
oral sex =3 *gross indec. =6*

CHILDHOOD DISTURBANCE *(no = 0, yes = 1)*

-BULLIED..... **Bac15** 
-BEING A BULLY..... **Bac16**
-FRIENDSHIP DIFFICULTIES..... **Bac17** 
-MISERABLE A LOT..... **Bac18**
-STEALING..... **Bac19**
-RUNNING AWAY..... **Bac20**
-DELIBERATE SELF HARM..... **Bac21**
-AGGRESSION..... **Bac22**
TWO OR MORE OF THE ABOVE..... **Bac23**

EVER TAKEN INTO LOCAL AUTHORITY CARE? *(n = 0, y = 1)* **care** 

SIGNIFICANT TRUANCY FROM SCHOOL? *(no = 0, yes = 1)*..... **truant** ☐
LITERATE..... **Bac24** ☐

no =0
partially =1
yes =2

SCHOOLING..... **Bac25** ☐

special school =1
<16 =2
<18 =3
18+ =4

CONTACT WITH PSYCHOLOGY/PSYCHIATRIC SERVICES AS CHILD
(no = 0, yes = 1)..... **Bac26** ☐
CONTACT WITH PSYCHOLOGY/PSYCHIATRIC SERVICES AS ADULT *(no = 0, yes = 1)*..... **Bac27** ☐
HISTORY OF SELF HARM *(no = 0, yes = 1)*..... **Bac28** ☐
SELF-REPORTED PSYCHOLOGICAL PROBLEMS..... **Bac29** ☐

none	=0	*nervous breakdown*	=3
alcohol abuse	=1	*other*	=4
drug abuse	=2		

SEX PLAY WITH OTHER BOYS AS A CHILD *(no = 0, yes = 1)*..... **Bac30** ☐
AGE AT FIRST GIRLFRIEND..... **Bac31** ☐☐
NO. OF LONG TERM RELS.(COHABITING 1+ YEARS)..... **Bac32** ☐
ADULT HOMOSEXUAL CONTACTS *(no = 0, yes = 1)*.....**Bac33** ☐
CHILDREN AT TIME OF OFFENCE *(no = 0, yes = 1)*:
BIOLOGICAL KIDS AT HOME..... **Bac34** ☐
BIOLOGICAL KIDS, AWAY..... **Bac35** ☐
STEP KIDS IN HOME..... **Bac36** ☐

OFFENDING BEHAVIOUR

PREVIOUS SEXUAL OR VIOLENT OFFENCES? *(no = 0, yes = 1)* **presxv** ☐
PREVIOUS CONVICTIONS..... **Off01** ☐
Off02 ☐
Off03 ☐

none	=0	*violent*	=3
sexual (child)	=1	*property*	=4
sexual (adult)	=2	*minor*	=5
possession of indecent material			=6

INDEX CONVICTIONS..... **Off04** ☐
Off05 ☐
Off06 ☐

rape	=1	*exposure*	=5	*encouraging*	
USI	=2	*gross ind*	=6	*prostitution*	=10
buggery	=3	*other*	=7	*incest*	=11
indec ass	=4	*possession of child pornography*			=8

NUMBER OF VICTIMS..... **Off07** ☐☐
AGE OF VICTIMS..... **Off08** ☐☐
Off09 ☐☐
Off10 ☐☐

AVERAGE AGE OF VICTIMS..... **vicage** ☐☐

VICTIM SEX..... **VS01**

male =0 *both =2*

female =1

VICTIM RELATIONSHIP..... **Off1**

step (homo)	*=1*	*relative (hetero)*	*=6*	**Off2**
step (hetero)	*=2*	*acquaint (homo)*	*=7*	**Off3**
father (homo)	*=3*	*acquaint (hetero)*	*=8*	
father (hetero)	*=4*	*stranger (homo)*	*=10*	
relative (homo)	*=5*	*stranger (hetero)*	*=11*	

EXTRAFAMILIAL VICTIM? *(no = 0, yes = 1)*..... **extraf**

FORM OF ABUSE..... **Off4**

fondled	*=1*	*buggery*	*=5*	**Off5**
masturbation	*=2*	*gross indec*	*=6*	**Off6**
oral sex	*=3*	*intercourse*	*=7*	
digital pen	*=4*	*other*	*=8*	

PENETRATIVE ABUSE? *(no = 0, yes = 1)*..... **penetra**

NUMBER OF TIMES..... **Numb**

DURATION OF ABUSE (months)..... **Off7**

DIRECT VERBAL THREATS: *(no = 0, yes = 1)*..... **Off8**

PHYSICAL COERCION: *(no = 0, yes = 1)*..... **Off9**

BRIBES: *(no = 0, yes = 1)* **Off0**

GENERAL AGGRESSION..... **Off1**

none	*=0*	*to child*	*=2*	**Off2**
to partner	*=1*	*to objects*	*=3*	**Off3**

LOCATION OF ABUSE:..... **Off4**

victim's home =1 *perpetrator's home = 4*

outside =2

both =3

UNCONVICTED ALLEGATIONS:..... **Off5**

NUMBER OF VICTIMS..... **Off6**

AGE OF VICTIMS..... **Off7**

Off8

Off9

VICTIM RELATIONSHIP..... **Off0**

step (homo)	*=1*	*relative (hetero)*	*=6*	**Off1**
step (hetero)	*=2*	*acquaint (homo)*	*=7*	**Off2**
father (homo)	*=3*	*acquaint (hetero)*	*=8*	
father (hetero)	*=4*	*stranger (homo)*	*=10*	
relative (homo)	*=5*	*stranger (hetero)*	*=11*	

FORM OF ABUSE..... **Off3**

fondled	*=1*	*buggery*	*=5*	**Off4**
masturbation	*=2*	*gross indec*	*=6*	**Off5**
oral sex	*=3*	*intercourse*	*=7*	
digital pen	*=4*	*other*	*=8*	

LIFE EVENT TRIGGERS..... **Off6**

none	*=0*	*abandoned*	*=3*	*work = 6*	**Off7**

sexual probs =1 *redundancy =4* **Off38**
marital disc. =2 *bereavement =5*

GENERAL PORNOGRAPHY USE..... Off39 ☐
denied =0 *child =2*
adult =1 *both =3*

DEVIANT FANTASIES DURING PERIOD OF OFFENDING..... Off40 ☐
denied =0 *some =1* *frequent =2*

SUBSTANCE ABUSE AT TIME OF OFFENDING..... Off41 ☐
none =0 *heavy drug =3* **Off42** ☐
moderate drug =1 *heavy alcohol =4*
moderate alcohol =2

CURRENT DENIAL..... Att1 ☐
total denial =0 *both =3*
partial denial of acts =1 *full acceptance =4*
partial denial of responsib =2

PREVIOUS TREATMENT RECEIVED..... Att2 ☐
none =0 *group =4*
indiv =1 *group/ prison =5*
indiv/ prison =2

MOTIVATION FOR CHALLENGE..... Att3 ☐
none =0 *could happen again =3* **Att4** ☐
avoid prison =1 *its a problem =4*
reunite with family =2

OUTCOME

RECOMMENDATIONS..... Recomm ☐
none made =0 *not suitable due to risk or seriousness*
challenge =1 *of offence =3*
suitable,but refused =2 *not suitable, more appropriate*
for other treatment services =4
not seen =5

☐

ACTUAL OUTCOME..... Out1
probation =1 *licence plus treatment =4*
probation plus treatment =2 *custody =5*
licence =3 *parole refused =6*

IF OUTCOME=5, SENTENCE LENGTH (MONTHS)..... Out2 ☐☐☐
HAS OUTCOME CHANGED?..... Out3 ☐
no= 0, yes=1
IF YES, FINAL OUTCOME..... Out4 ☐
probation =1 *licence plus treatment =4*
probation plus treatment =2 *custody =5*
licence =3 *parole refused =6*
voluntary att =7

FINAL RESEARCH STATUS..... Out5 ☐
group =1 *relapse group only =4*
individual (chall manual) =2 *miscellaneous-*
individual (psychotherapy) =3 *never went into treatment =5*

ATTENDANCE DURING TREATMENT..... **Attend** ☐

full attendance =0 missed 2 sessions =2
missed 1 session =1 missed <2 sessions =3
no treatment =4

COMPLIANCE/ NON COMPLIANCE..... **Comply** ☐

Non-compliant =0, compliant = 1, no treatment = 2

THORNTON RISK ALGORITHM

PRELIMINARY RISK **Thornpre** ☐

Low risk = 1, Medium risk = 2, High risk = 3

FINAL RISK **Thornfin** ☐

Low risk = 1, Medium risk = 2, High risk = 3

BEHAVIOUR-RISK-SERIOUSNESS

BEHAVIOUR - PROB. OFFICER (INITIAL) **Behapo1** ☐

Never happened = 1 Everything but most serious =4
Very minor = 2 Admits everything =5
At least half admits = 3

RESPONSIBILITY – PROB. OFFICER (INITIAL) **Resppo1** ☐

It wasn't me =1 If only V had stopped me =4
Victim seduced me =2 Complete acceptance of R =5
Some responsibility =3

SERIOUSNESS – PROB. OFFICER (INITIAL) **Serpo1** ☐

V enjoyed it =1 V won't forget but will get on =4
Court/police more damaging =2 Permanent damage =5
V disturbed but will pass =3

BEHAVIOUR - PSYCHOLOGIST (INITIAL) **Behapsy1** ☐

Never happened = 1 Everything but most serious =4
Very minor = 2 Admits everything =5
At least half admits = 3

RESPONSIBILITY – PSYCHOLOGIST (INITIAL) **Resppsy1** ☐

It wasn't me =1 If only V had stopped me =4
Victim seduced me =2 Complete acceptance of R =5
Some responsibility =3

SERIOUSNESS – PSYCHOLOGIST (INITIAL) **Serpsy1** ☐

V enjoyed it =1 V won't forget but will get on =4
Court/police more damaging =2 Permanent damage =5
V disturbed but will pass =3

INITIAL TEST RESULTS

INTELLIGENCE (SCHONELL)..... Score **Test05** ☐☐

Level: MI=1; bord=2; low=3; av=4; gd av=5; high=6 **Test06** ☐

BUSS-DURKEE HOSTILITY INVENTORY..... Score **Test07** ☐☐

Low = 1, Average = 2, High = 3 **Test08** ☐

MULTIPHASIC SEX INVENTORY

social/sexual desirability..... Test10
sexual obsessions..... Test11
lie scale..... Test12

cognitive distortion..... Test13
justifications..... Test14
treatment attitudes..... Test15

child molest..... Test16
fetish..... Test17
voyeurism..... Test18
obscene call..... Test19
bondage..... Test20
sado-masochism..... Test21

sexual dysfunction..... Test22
sex knowledge..... Test23

***LOCUS OF CONTROL.....** Score **Test24**
Average = 0, Internal = 1, External = 2 **Test25**

***SELF ESTEEM.....** Score **Test26**
Normal = 0, Low = 1 **Test27**

*These questionnaires are used from Sub 283 (plus Sub 274)

INTERPERSONAL REACTIVITY INDEX

fantasy scale..... Var01

perspective scale..... Var02
empathic concern scale..... Var03
personal distress scale..... Var04

PARENTAL BONDING SCALE

mother care..... Var05
mother protection..... Var06
father care..... Var07
father protection..... Var08

PARENTAL BONDING MATRIX

Mother..... Var09

Average	*= 1*	*Affectionate constraint*	*= 4*
Optimal bonding	*= 2*	*Affectionless control*	*= 5*
Absent or weak bonding	*= 3*		

Father..... Var10

Average	*= 1*	*Affectionate constraint*	*= 4*
Optimal bonding	*= 2*	*Affectionless control*	*= 5*

Absent or weak bonding = *3*

APPENDIX II

DEFINITION OF KEY VARIABLES

Subject variables

Child molester

Subjects were classified as child molesters if the official record of their index offence involved a contact sex offence against a child (aged up to sixteen), regardless of the nature of the conviction.

Rapist

Subjects were classified as rapists if the official record of their index offence involved a contact sex offence against an adult (aged more than sixteen), regardless of the nature of the conviction.

Developmental variables

Sexual victimisation in childhood

Ratings of sexual victimization were based upon self-report in interview, and corroborative information was sometimes available in previous mental health and probation reports, or the prosecution evidence. Interviewed subjects were asked whether they had experienced unwanted sexual contact under the age of 16 and detail was gathered regarding their early sexual experiences. The issue was approached from a number of angles: For example, subjects were asked "tell me about your first sexual experience". "Did you ever get involved in sex play with other boys". "Have you ever been touched by someone in a sexual way when you were a child, which made you feel uncomfortable". Any affirmative or ambiguous answers were followed up. Sexual

victimization was defined as sexual contact with another person that was either unwanted or perpetrated by an adult at least five years older than the subject. Consenting sexual contact with peers was coded separately.

Physical victimisation in childhood

Ratings of physical abuse in childhood were defined as physical contact, perpetrated by an adult on a number of occasions, which was unprovoked, or excessive in relation to any misdemeanor committed by the subject.

Emotional abuse/physical neglect in childhood

Ratings of emotional or physical neglect in childhood were defined as persistent and marked failures on behalf of the caring adult(s) to provide adequate and consistent care.

Childhood 'disturbance'

A number of variables were considered – on the basis of self report - which are associated with emotional or conduct disorder in childhood. These included ratings (before the age of 16) for persistent truanting or school refusal, significant episodes of being bullied or bullying others, suspension from school for aggression, stealing, running away from home, deliberate self harm, experiencing prolonged difficulties with peer friendships and marked feelings of misery. Subjects were defined as having experienced childhood disturbance/difficulties if they reported two or more of the above.

Adult difficulties

Contact with mental health services as an adult

This information was based upon self-report in interview with the psychologist. Subjects were asked whether they had seen a psychologist or psychiatrist in adulthood for reasons other than referrals directly connected with legal proceedings and their

offending behaviour. If the answer to this question was affirmative, then further details were requested, including the reason for contact with mental health services, and any hospital admissions.

Outcome variables

Treatment attrition

Treatment attrition was defined as failure to attend the full treatment program for any reason whatsoever. This was then broken down into:

a) Two or more missed treatment sessions, for unacceptable reasons
b) Two or more missed treatment sessions, including absences due to sickness (medical note available)
c) Dropping out of treatment prior to completion
d) Removal from treatment due to extenuating circumstances (for example, a deterioration in mental health, or geographical relocation of the client)

Treatment non-compliance

Treatment non-compliance was defined as having missed two or more sessions of treatment and/or were breached, re-arrested or re-convicted for any reason during the course of treatment, thus failing to comply with the explicit conditions of their probation order or license on release from custody. Compliance therefore, for the purposes of this study, did not refer to the quality of participation in treatment, or the attainment of treatment goals.

Formal failures

Reconviction data was available from the Home Office Criminal Index, and corroborated from probation and forensic mental health files. Probation files also contained data on breach and recall decisions in relation to sexual offenders who had not re-offended, but were taken back to court or into custody as a result of inappropriate behaviour or non compliance with statutory or treatment expectations. Thus *failure* in the community was subdivided into sexual, violent, or general re-convictions, and breach.

'Sexually risky behaviours'

Close collaborative working relationships between probation, social services and forensic mental health, led to additional information being available regarding sexually risky behaviours (SRB). This variable was intended to capture behaviours which might reasonably be thought of as sexual offending or 'approach' behaviours that were close to sexual offending, and included:

a) Sexual re-convictions, arrests and charges for sexual offences
b) Violent re-convictions with a clear sexual element
c) Breach for high risk behaviours (for example, individuals observed to be following potential victims, entering households against advice where potential victims were available, or heavy drinking which was previously associated with sexual offending)
d) Child protection investigations in relation to new allegations or concerns, regardless of the outcome

APPENDIX III

PARENTAL BONDING INSTRUMENT

Answer the questions as you remember your parents in your first sixteen years.
Please put a tick in the column which describes them as they were

	My mother / father (delete as appropriate)	Very similar to	Quite similar to	Not very similar to	Not at all similar to
1	Spoke to me with a warm and friendly voice	☐	☐	☐	☐
2	Helped me as much as I needed	☐	☐	☐	☐
3	Let me do things I liked doing	☐	☐	☐	☐
4	Seemed emotionally cold to me	☐	☐	☐	☐
5	Appeared to understand my problems and worries	☐	☐	☐	☐
6	Was affectionate to me	☐	☐	☐	☐
7	Liked me to make my own decisions	☐	☐	☐	☐
8	Wanted me to grow up	☐	☐	☐	☐
9	Tried to control everything I did	☐	☐	☐	☐
10	Invaded my privacy	☐	☐	☐	☐
11	Enjoyed talking things over with me	☐	☐	☐	☐
12	Frequently smiled at me	☐	☐	☐	☐
13	Tended to baby me	☐	☐	☐	☐
14	Seemed to understand what I needed or wanted	☐	☐	☐	☐
15	Let me decide things for myself	☐	☐	☐	☐
16	Made me feel I wasn't wanted	☐	☐	☐	☐
17	Could make me feel better when I was upset	☐	☐	☐	☐
18	Talked to me often	☐	☐	☐	☐
19	Tried to make me dependent on her / him	☐	☐	☐	☐
20	Felt that I could not look after myself unless she / he was around	☐	☐	☐	☐
21	Gave me as much freedom as I wanted	☐	☐	☐	☐
22	Let me go out as often as I wanted	☐	☐	☐	☐
23	Was overprotective of me	☐	☐	☐	☐
24	Praised me	☐	☐	☐	☐
25	Let me dress in any way I pleased	☐	☐	☐	☐

Figure 6.5: Parental bonding questionnaire (Parker et al, 1979)

LIST OF REFERENCES

Abel, G. G., Mittelman, M., Becker, J., Rathner, J. & Rouleau, J. (1988). Predicting child molesters' response to treatment. In R. A. Prentky & V.L. Quinsey (Eds.) *Annals of the New York Academy of Science*, pp. 223-235. New York: N.Y.Academy of Science.

Ainsworth, M.D.S. (1980). Attachment and child abuse. In G. Gerbner, C.J. Ross, & E. Zigler (Eds.), *Child Abuse: An agenda for action* (pp. 35-47). New York: Oxford University Press.

Alexander, M.A. (1999) Sexual offender treatment efficacy revisited. *Sexual Abuse: A Journal of Research and Treatment,* 11 101-116

American Psychiatric Association (1994*). Diagnostic and Statistical Manual of Mental Disorders - 4th Edition.*. Washington, DC.

Baker, A. & Duncan, S.I. (1985). Child sexual abuse: a study of prevalence in Great Britain. *Child Abuse and Neglect,* 9, 457-467.

Bard, L.A., Carter, D.L., Cerce, D.D., Knight, R.A., Rosenberg, R., & Schneider, B. (1987). A descriptive study of child molesters, developmental, clinical and criminal characteristics. *Behavioral Sciences and the Law, 5,* 203-220.

Beckett, R., Beech, A., Fisher, D., & Fordham, A. (1994) *Community-based treatment for sex offenders: an evaluation of seven treatment programs.* London: HMSO

Beckett, R., and Fisher, D. (1994) Assessing victim empathy: A new measure. *Paper presented at the 13th Annual Conference of ATSA (the Association for the Treatment of Sexual Abusers).* San Francisco: USA

Beech, A. (1998). A psychometric typology of child abusers. *International Journal of Offender Therapy and Comparative Criminology, 42(4),* 319-339.

Beech, A., Fisher, D. & Beckett, R. (1999). An Evaluation of The Prison Sex Offender Treatment Programme. *UK Home Office Occasional Report*. Available from Home Office Publications Unit, 50 Queen Anne's Gate, London SW1 9AT, England.

Beech, A. & Fisher, D. (2000). Maintaining relapse prevention skills and strategies in treated child abusers. In D.R. Laws, S.M. Hudson and T.Ward (Eds) *Remaking Relapse Prevention with Sex Offenders: A Sourcebook.* Sage Publications.

Beech, A.R., & Fordham, A. (1997). Therapeutic climate of sexual offender treatment programmes. *Sexual Abuse: a Journal of Research and Therapy, 9,* 219-237.

Beech, A., Friendship, C., Erikson, M., & Hanson, R. (2002), The Relationship Between Static and Dynamic Risk Factors and Reconviction in a Sample of U.K. Child Abusers. *Sexual Abuse: A Journal Of Research And Treatment, 14,* 155-167.

Beitchman, J., Zucker, K., Hood, J., DaCosta, G. , Akman, D. & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect, 16,* 101-118.

Boswell, G. (1995). *The prevalence of abuse and loss in the lives of Section 53 offenders.* School of Social Work, University of East Anglia/ Prince's Trust, London.

Bowlby, J. (1977). The Making and Breaking of Affectional Bonds. *British Journal of Psychiatry, 130,* 201-210.

Bowlby, J. (1979). *The Making and Breaking of Affectional Bonds*. Tavistock Publications: London.

Bowlby, J. (1983). *A Secure Base: Clinical Applications of Attachment Theory*. Routledge: London.

Briere, J. & Smiljanich, K. (1993). *Childhood sexual abuse and subsequent sexual aggression against adult women.* Paper presented at the 101s[t] annual convention of the American Psychological Association, Toronto, Ontario.

Briggs, F. & Hawkins, R. (1996). A comparison of the childhood experiences of convicted male child molesters and men who were sexually abused in childhood and claimed to be nonoffenders. *Child Abuse & Neglect, 20(3)*, 221-233.

Browne, K. D. (1994) 'Child Sexual Abuse' In J. Archer (Ed.) *Male Violence.* London: Routledge, pp. 210-230.

Browne, K.D., & Herbert, M. (1997). *Preventing Family Violence*. Chichester:Wiley.

Burt, M. (1980). Cultural myths and support for rape. *Journal of Personality and Social Psychology, 39,* 217-230.

Buss, A.H. & Durkee, A. (1957). An inventory for assessing different kinds of hostility. *Journal of Consulting Psychology, 21*, 343-349.

Cavedo, L.C., & Parker, G. (1994). Parental Bonding Instrument: exploring for links between scores and obsessionality. *Social Psychiatry Psychiatric Epidemiology, 29,* 78-82.

Cawson, P., Wattam, C., Brooker, S. and Kelly, G. (2000*). Child Maltreatment in the United Kingdom: A study of the prevalence of Child Abuse and Neglect.* London: NSPCC.

Chaffin, M. (1992). Factors associated with treatment completion and progress among intrafamilial sexual abusers. *Child Abuse & Neglect, 16,* 251-274.

Cook, D., Fox, C., Weaver, C. & Rooth, F. (1991). The Berkeley Group: 10 years experience of a group for non-violent sex offenders, *British Journal of Psychiatry, 158,* 238-243.

Craissati, J. (1998) *Child sexual abusers: A community treatment approach*. London: Psychology Press.

Craissati, J. & Beech. A. (2001) Attrition in a community treatment program for child sexual abusers. *Journal of Interpersonal Violence,* 16, 205-221

Craissati, J., & Beech, A. (2003), A Review of Dynamic Variables and their Relationship to Risk Prediction in Sex Offenders. *Journal of Sexual Aggression*. In press.

Craissati, J., & Beech, A. (2004), The characteristics of convicted rapists: Sexual victimization and compliance in comparison to child molesters. *Journal of Interpersonal Violence, 19* , (in press)

Craissati, J., & Beech, A. (2002) Risk prediction and failure in a complete geographical sample of sex offenders. *Submitted for publication*

Craissati, J., Falla, S., & McClurg, G. (2000) *The Challenge Project. Child Sexual Abusers in South East London: profile, treatment and outcome*. Internal Document: Oxleas NHS Trust

Craissati, J., Falla, S., McClurg, G. & Beech, A. (2002) Risk, reconviction rates and pro-offending attitudes for child molesters in a complete geographical area of London. *Journal of Sexual Aggression, 8,* 22-38

Craissati, J., & McClurg, G. (1996) The Challenge Project: perpetrators of child sexual abuse in S.E.London. *Child Abuse and Neglect,* 20, 1067-1077

Craissati, J., & McClurg, G. (1997) The Challenge Project: a treatment program evaluation for perpetrators of child sexual abuse. *Child Abuse and Neglect,* 21, 637-648

Craissati, J., McClurg, G., & Browne, K. (2002a). Characteristics of perpetrators of child sexual abuse who have been sexually victimized as children. *Sexual Abuse: A Journal of Research and Treatment, 14(3),* 225-239

Craissati, J., McClurg, G., & Browne, K. (2002b) The parental bonding experiences of sex offenders: a comparison between child molesters and rapists. *Child Abuse and Neglect, 26,* 909-921

Creighton, S. and Russell, N. (1995). *Voices from Childhood: A survey of childhood experiences and attitudes to childrearing among adults in the United Kingdom.* London: NSPCC

Davis, M.H. (1980). A multidimensional approach to individual differences in empathy. *JSAS Catalog of Selected Documents in Psychology, 10,* 85.

Dean, K., & Malamuth, N.M. (1997). Characteristics of men who aggress sexually and of men who imagine aggressing: Risk and moderating variables. *Journal of Personality and Social Psychology, 72,* 449-455.

Dhawan, S., & Marshall, W.L. (1996). Sexual abuse histories of sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 8(1),* 7-15.

Dobash, R.P., Carnie, J. and Waterhouse, L. (1993) Child Sexual Abusers: Recognition and Response. In L. Waterhouse (Ed.) *Child Abuse and Child Abusers* pp.113 - 135

Douglas, K.S., Cox, D.N., & Webster, C.D. (1999). Violence risk assessment: Science and practice. *Legal and Criminological Psychology, 4,* 149-184.

Dutton, D.G.,Saunders, K., Statzomski, A.J., & Bartholomew, K. (1994). Intimacy, anger and insecure attachment as precursors of abuse in intimate relationships. *Journal of Applied Social Psychology. 24,* 1367-1386.

Eliott, M., Browne, K.D. and Kilcoyne, J. (1995). Child sexual abuse: what offenders tell us.

Child Abuse and Neglect, 19(5): 579-594

Falshaw, L., Browne, K.D. & Hollin, C.R. (`1996). Victim to offender: A review.

Aggression and Violent Behaviour, 1, 389-404.

Falshaw, L., & Browne, K.D. (1997). Adverse childhood experiences and violent acts of young people in secure accommodation. *Journal of Mental Health,* 6(5) 443-455.

Falshaw, L., Browne, K.D., & Hollin, C. (1996). Victim to Offender: A Review. *Aggression and Violent Behavior*, 1 (4): 389-404.

Fedora, O., Reddon, J., Morrison, J., Fedora, S., Pascoe, H., & Yeudall, L. (1992). Sadism and other paraphilias in normal controls and aggressive and nonaggressive sex offenders. *Archives of Sexual Behavior, 21(1),* 1-15.

Finkelhor, D. (Ed.) (1984). *Child Sexual Abuse: New Theory and Research.* New York: Free Press.

Finkelhor, D. (1986). *A sourcebook on child sexual abuse*. California: Sage.

Finkelhor, D. (1995). 'The victimisation of children: a developmental perspective'. *American Journal of Orthopsychiatry,* 65 (2): 177-193.

Finkelhor, D., Hotaling, G., Lewis, I., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: prevalence, characteristics, and risk factors. *Child Abuse and Neglect, 14,* 19-28.

Firestone, P., Bradford, J., McCoy, M., Greenberg, M., Curry, S., & Larose, M. (2000). Prediction of recidivism in extrafamilial child molesters based on court-related assessments. *Sexual Abuse: A Journal of Research and Treatment, 12* ,203-221.

Firestone, P., Bradford, J., McCoy, M., Greenberg, D., & Larose M. (1999) Prediction of recidivism in incest offenders. *Journal of Interpersonal Violence,* 14, 511-531

Fisher, D., Beech, A. & Browne, K. (1998). Locus of control and its relationship to treatment change and abuse history in child sexual abusers. *Legal and Criminological Psychology, 3,* 1-12.

Fisher, D., & Thornton, D. (1993). Assessing risk of re-offending in sexual offenders. *Journal of Mental Health, 2,* 105-117.

Freund, K., Chan, S., & Coulthard, R. (1979). Phallometric diagnosis with 'nonadmitters'. *Behavior, Research and Therapy,17,* 451-457.

Freeman-Longo, R.E. (1986). The impact of sexual victimization on males. *Child Abuse & Neglect, 10,* 411-414.

Friendship, C., & Thornton, D. (2001), Sexual Reconviction for Sexual Offenders Discharged from Prison in England and Wales: Implications for Evaluating Treatment. *British Journal Of Criminology, 41*, 285-292.

Furby, L., Weinrott, M. & Blackshaw, L. (1989). Sex offender recidivism: a review. *Psychological Bulletin, 105(1),* 3-30.

George, C., Kaplan, M., & Main, M. (1984). *Attachment Interview for Adults.* Unpublished manuscript, University of California, Berkeley.

George, W.H., & Marlatt, G.A. (1989). Introduction. In R.D. Laws (Ed.), *Relapse Prevention with Sex Offenders (pp. 1-31).* New York: The Guildford Press.

Gillis, J.R. (1991) *The rapist as a sexually deviant offender.* Unpublished doctoral dissertation. Queens University, Kingston, Ontario, Canada

Glasser, M. (1988). Psychodynamic aspects of paedophilia. *Psychoanalytic Psychotherapy, 3,* 121-135.

Griffin, D.W., & Bartholomew, K. (1994). The metaphysics of measurement: the case of adult attachment. In K. Bartholomew & D. Perlman (Eds.), *Attachment processes in adulthood (pp. 17-52).* London: Jessica Kingsley.

Grubin, D. (1998) *Sex Offending against Children: Understanding the Risk.* Police Research Series, Paper 99. Home Office Policing and Reducing Crime Unit, 50 Queen Anne's Gate, London SW1H 9AT, UK

Grubin, D., & Wingate, S. (1996), Sexual Offence Recidivism: Prediction Versus Understanding. *Criminal Behaviour And Mental Health, 6*, 349-359.

Grusznski, R. J. & Carrillo, T. P. (1988). Who completes batterer's treatment groups? An empirical investigation. *Journal of Family Violence, 3(2),* 141-150.

Haapasalo, J., & Kankkonen, M. (1997). Self-reported childhood abuse among sex and violent offenders. *Archives of Sexual Behavior, 26(4),* 421-431.

Hall, G. (1995) Sexual offender recidivism revisited: a meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology*, 63, 802-809

Hamilton, C. E. & Browne, K. D. (1998). The repeat victimisation of children: should the concept be revised? *Aggression & Violent Behavior*, 3(1): 47-60.

Hamilton, C.E., Falshaw, L., & Browne, K.D. (2002) Recurrent Maltreatment and its link to offending behavior. *International Journal of Offender Therapy and Comparative Criminology 45, in press.*

Hanson, R., & Bussiere, M. (1998) Predicting relapse: a meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, 86, 348-362

Hanson. R., Cox, B. & Woszcsyna, C. (1991) *Sexuality, Personality and Attitude. Questionnaires for Sexual Offenders: A Review*. Ministry of the Solicitor General of Canada, 340 Laurier Ave., West Ottawa, Ontario, Canada, K1A 0P8

Hanson, R., Gordon, A., Harris, A., Marques, J., Murphy, W., Quinsey, V., & Seto, M. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14(2),* 169-194.

Hanson, K., & Harris, A. (1998). *Dynamic Predictors of Sexual Recidivism*. Available from Department of the Solicitor General of Canada, 340 Laurier Ave, West, Ottawa, Ontario, Canada, K1A 0P8

Hanson, K., & Harris, A. (2000). *The Sex Offender Need Assessment Rating (SONAR): a Method for Measuring Change in Risk Levels.* Available from Department of the Solicitor General of Canada, 340 Laurier Ave, West, Ottawa, Ontario, Canada, K1A 0P8.

Hanson, R.K., & Harris, A.J.R. (2001). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 13,* 105-122.

Hanson, R., & Slater, S. (1988). Sexual victimization in the history of child sexual abusers: a review. *Annals of Sex Research, 1,* 485-499.

Hanson, R.K., Steffy, R.A., & Gauthier, R. (1993). Long-term recidivism of child molesters. *Journal of Consulting and Clinical Psychology, 61,* 646-652.

Hanson, R., & Thornton, D. (1999) *Static 99: Improving Actuarial Risk Assessments for Sex Offenders.* Available from Department of the Solicitor General of Canada, 340 Laurier Ave., West, Ottawa, Ontario, Canada, K1A 0P8

Hanson, R., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior, 24,* 119-136.

Hare, R.D. (1991). *Manual for the revised Psychopathy Checklist*. Toronto: Multi-Health Systems.

Harris, J. & Grace, S. (1999). *A Question of Evidence? Investigating and Prosecuting Rape in the 1990s.* Home Office Research Study 196. London: Home Office.

www.homeoffice.gov.uk/rds/violencewomen.html

Hedderman, C., & Sugg, D. (1996) *Does Treating Sex Offenders Reduce Reoffending?* Research findings no.45. London: HMSO

Home Office (1995). *Criminal statistics England and Wales*. London: HMSO.

Home Office (1997). *Aspects of Crime: Children as Victims*. Crime & Criminal Justice Unit, Research and Statistics Directorate, Home Office, 50 Queen Anne's Gate, London SW1H 9AT, England.

Home Office Circular (HOC 39/1997), *Sex Offenders Act 1997*. London: Home Office.

Home Office (2000), *Government Proposals Better To Protect Children From Sex And Violent Offenders*. Home Office News Release, 15 September 2000.

Hudson, S.M., & Ward, T. (1997a). Intimacy, loneliness and attachment styles in sexual offenders. *Journal of Interpersonal Violence, 12(3)*, 323-339.

Hudson, S., & Ward, T. (1997b). Rape: psychopathology and theory. In D.R. Laws & W. O'Donohue (Eds.), *Sexual Deviance: Theory, assessment, and treatment*. pp 332-355. Hedderman, C. & Sugg, D. (1996) *Does Treating Sex Offenders Reduce Reoffending*? Research findings no.45. London: HMSO

Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry, 57,* 186-192.

Kennedy, H.G., & Grubin, D.H. (1992). Patterns of denial in sex offenders. *Psychological Medicine, 22,* 191-196.

Knight, R., & Prentky, R. (1990). Classifying sexual offenders: The development and corroboration of taxonomic models. In H.E. Barbaree, W.L. Marshall, & S.M.

Hudson (Eds.), *The Juvenile Sex Offender (pp.45-83).* New York: Guilford Press.

Knight, R., & Sims-Knight, J. (2002). The developmental antecedents of sexual coercion against women in adolescents. In R. Geffner & K. Franey (Eds.) *Sex Offenders: Assessment and Treatment.* New York: Haworth Press (in press).

Langevin, R. (1983). *Sexual Strands: Understanding and treating sexual anomalies in men.* Hillsdale, NJ: Lawrence Erlbaum.

Langevin, R. (1988). Defensiveness in sex offenders. In R. Rogers (Ed.), *Clinical assessment of malingering and deception.* New York: Guilford Press.

Langevin, R., Wright, P., & Yhandy, L. (1989). Characteristics of sex offenders who were sexually victimized as children. *Annals of Sex Research, 2,* 227-253.

Launay, G. (in press) Relapse Prevention with sex offenders: practice, theory and research. *Journal of Forensic Psychiatry*

MacCullock, M.J., Snowden, P.R., Wood, P.J., & Mills, H.E. (1983). Sadistic fantasy, sadistic behavior and offending behavior. *British Journal of Psychiatry, 143,* 20-29.

Malamuth, N.M., Heavy, C.L., & Linz, D. (1993). Predicting men's antisocial behavior against women: the interaction model of sexual aggression. In G.C.N. Hall, R. Hirschman, J.R. Graham, & M.S. Zaragoza (Eds.) *Sexual aggression: Issues in etiology, assessment, and treatment (*pp. 63-97). Washington, DC: Taylor & Francis.

Maletzky, B. (1991). *Treating the Sex Offender.* Newbury Park, CA: Sage.

Marques, J. K. (1999). How to answer the question "does sex offender treatment work?". *Journal of Interpersonal Violence, 14(4),* 437-451.

Marques, J., Day, D., Nelson, C., & West, M. (1994). Effects of cognitive-behavioral treatment on sex offender recidivism. *Criminal Justice and Behavior, 21,* 28-54.

Marshall, P. (1997). *The prevalence of convictions for sexual offending.* Home Office Research and Statistics Directorate.

Marshall, W.L. (1989). Intimacy, loneliness and sexual offenders. *Behavior Research and Therapy, 27(5),* 491-503.

Marshall, W.L. (1993) The role of attachments, intimacy, and loneliness in the etiology and maintenance of sexual offending. *Sexual and Marital Therapy, 8,* 109-121

Marshall, W. (1994). Treatment effects on denial and minimization in incarcerated sex offenders. *Behavior, Research and Therapy, 32(5),* 559-564.

Marshall, W.L. (1997) Pedophilia: Psychopathology and theory. In D.R. Laws & W. O'Donohue (eds.) *Sexual Deviance: Theory, Assessment, and Treatment.* New York: The Guilford Press

Marshall, W., & Barbaree, H. (1988), The Long-Term Evaluation of a Behavioral Treatment Program for Child Molesters. *Behaviour Research And Therapy, 6,* 499-511.

Marshall, W.L., Hudson, S.M., & Hodkinson, S. (1993). The importance of attachment bonds in the development of juvenile sex offending. In H.E. Barbaree, W.L. Marshall, & S.M. Hudson (Eds.), *The Juvenile Sex Offender (*pp. 164-181). New York: Guildford Press.

Marshall, W.L. & Kennedy, P. (2001). Sexual sadism in sexual offenders. An elusive diagnosis. *Aggression and Violent Behavior, 7,* 1-22.

Marshall, W. L. & Pithers, W. D. (1994). A reconsideration of treatment outcome with sex offenders. *Criminal Justice & Behaviours, 21(1),* 10-27.

McClurg, G. & Craissati, J. (1999) A descriptive study of alleged child molesters known to social services. *Journal of Sexual Aggression*, 4, 22-30

Mendel, M. (1995). *The male survivor: the impact of sexual abuse.* California: Sage Publications.

Morton, N., & Browne, K.D. (1998). Theory and Observation of Attachment and its Relation to Child Maltreatment: A Review. *Child Abuse & Neglect, 22* (11): 1093-1104.

Murphy, W.D., Haynes, M.R., & Worley, P.J. (1991). Assessment of adult sexual interest. In C.R. Hollin & K. Howells (Eds.) *Clinical approaches to sex offenders and their victims.* Chichester: Wiley.

Nichols, H.R. & Molinder, I. (1984) *Multiphasic Sex Inventory Manual.* Available from 437 Bowes Drive, Tacoma, WA 98466, USA

Nowicki, S. (1976). *Adult Nowicki-Strickland Internal-External Locus of Control Scale.* Test Manual available from S. Nowicki, Jr., Department of Psychology, Emory University, Atlanta, GA 30322, USA.

Overholser, C., & Beck, S. (1986). Multimethod assessment of rapists, child molesters, and three control groups on behavioural and psychological measures. *Journal of Consulting and Clinical Psychology, 54,* 682-687.

Owen, G. & Steele, N. M. (1991). Incest offenders after treatment. In M. Q. Patton (Eds.) *Family Sexual Abuse.* London: Sage.

Paris, J., Zweig-Frank, H., & Guzder, J. (1994). Risk factors for borderline personality in male outpatients. *Journal of Nervous and Mental Disease, 182(7),* 375-380.

Parker, G., Tupling, H., & Brown, L.B. (1979). A Parental Bonding Instrument. *British Journal of Medical Psychology, 52,* 1-10.

Parker, G. (1983). *Parental Overprotection: a risk Factor in Psychosocial Development.* Grune and Stratton: New York.

Parker, G. (1990). The parental bonding instrument: a decade of research. *Social Psychiatry Psychiatric Epidemiology, 25,* 281-282.

Pithers, W.D. (1994). Process evaluation of a group therapy component designed to enhance sex offenders' empathy for sexual abuse survivors. *Behaviour Research and Therapy. 32(5),* 565-570.

Quinsey, V., Harris, G., Rice, M. & Lalumiere, M. (1993). Assessing treatment efficacy in outcome studies of sex offenders. *Journal of Interpersonal Violence, 8(4),* 512-523.

Quinsey, V., Lalumier, M., Rice, M., & Harris, G. (1995). Predicting sexual offenses. In J. Campbell (Ed.), *Assessing dangerousness: Violence by sexual offenders, batterers and child abusers.* pp 114-137. California: Sage.

Quinsey, V., Rice, M., & Harris, G. (1995). Actuarial prediction of sexual recidivism. *Journal of Interpersonal Violence, 10(1)*, 85-105.

Prentky, R. & Knight, R. (1991). Identifying critical dimensions for discriminating among rapists. *Journal of Consulting and Clinical Psychology, 59,* 643-661.

Prentky, R., Lee, A., Knight, R., & Cerce, D. (1997). Recidivism rates among child molesters and rapists: A methodological analysis. *Law and Human Behavior, 21(6),* 635-659.

Rice, M., & Harris, G. (1997). Cross-validation and extension of the violence risk appraisal guide for child molesters and rapists. *Law and Human Behavior, 21(2),* 231-241.

Rosen, I. (1979). *Sexual Deviation.* London: Oxford University Press.

Salter, A. (1988). *Treating Child Sex Offenders and Victims – a Practical Guide.* California: Sage.

Saunders, D. G. & Parker, J. C. (1989). Legal sanctions and treatment follow-through among me who batter: a multivariate analysis. *Social Work Research & Abstracts,* 21-29.

Seghorn, T.K., Prentky, R.A., & Boucher, R.J. (1987). Childhood sexual abuse in the lives of sexually aggressive offenders. *Journal of the American Academy of Child and Adolescent Psychiatry, 26,* 262-267.

Seto, M. C. & Barbaree, H. E. (1999). Psychopathy, treatment behavior and sex offender recidivism. *Journal of Interpersonal Violence, 14(12)*, 1235-1248.

Simkins, L., Ward, W., Bowman, S., & Rinck, C.M. (1989) The Multiphasic Sex Inventory as a predictor of treatment response in child abusers. *Annals of Sex Research*, 2, 205-226

Smallbone, S.W., & Dadds, M.R. (1998). Childhood attachment and adult attachment in incarcerated adult male sex offenders. *Journal of Interpersonal Violence, 13(5),* 555-573.

Smith-Heinzl, C., Henderson, A.J.Z., & Bartholomew, K. (1994). *A Prospective Study of Attachment Representations and Psychological Abuse.* Paper presented at the meeting of the American Psychological Association, Los Angeles.

Spence, J. T. & Helmreich, R. L. (1972). The attitudes towards women scale: an objective instrument to measure attitudes toward the rights and roles of women in contemporary society. *Psychological Documents, 2,* 153.

Thornton, D. (2002), Constructing and Testing a Framework for Dynamic Risk Assessment. *Sexual Abuse: A Journal Of Research And Treatment, 14,* 139-153.

Thornton, D., Friendship, C., Erikson, M., Mann, R., & Webster, S. (2002). Cross-Validation of a static instrument for predicting sexual recidivism. *Law and Human Behavior.* In submission.

Tolman, R. M. & Bhosley (1990). A comparison of two types of pregroup preparation for men who batter. *Journal of Social Service Research, 13,* 33-43.

Tong, L., Oates, K. & McDowell, M. (1987). Personality development following sexual abuse. *Child Abuse & Neglect, 11,* 371-383.

Ward, T., Hudson, S.M., & Marshall, W.L. (1996). Attachment style in sex offenders: a preliminary study. *The Journal of Sex Research, 33(1),* 17-26.

Ward, T., Hudson, S.M., Marshall, W.L., & Siegert, R. (1995). Attachment style and intimacy deficits in sexual offenders: a theoretical framework. *Sexual Abuse: A Journal of Research and Treatment, 7(4).* 317-335.

Ward, T., McCormack, J., Hudson, S., & Polaschez, D. (1997). Rape: assessment and treatment. . In D.R. Laws & W. O'Donohue (Eds.), *Sexual Deviance: Theory, assessment, and treatment.* pp 356-385. New York: The Guilford Press.

Warren, J., Hazelwood, R., & Dietz, P. (1996). The sexually sadistic serial killer. *Journal of Forensic Science, 41(6),* 970-974.

Watkins, B. & Bentovim, A. (1992). The sexual abuse of male children and adolescents: a review of current research. *Journal of Child Psychology & Psychiatry, 33(1),* 197-248.

Watson, D. & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Consulting and Clinical Psychology, 33,* 448-457.

Weeks, R. & Widom, C. (1998). Self-Reports of Early Childhood victimization Among Incarcerated Adult Male Felons. *Journal of Interpersonal violence, 13 (3),* 346-361.

Widom, C. S. (1989). The cycle of violence. Science, 244, 160-166.

Widom, C. S. (1991). Avoidance of criminality in abused and neglected children. *Psychiatry, 54,* 162-174.

Widom, C. S. & Ames, M. A. (1994). Criminal consequences of childhood sexual victimization. *Child Abuse and Neglect, 18*, 303-318.

Woike, B.A., Osier, T.J., & Candela, K. (1996). Attachment styles and violent imagery in thematic stories about relationships. *Personality and Social Psychology Bulletin, 22(10),* 1030-1034.

World Health Organisation (1994) *The International Statistical Classification of Diseases and Related Health problems - 10th Edition*. Geneva: Switzerland.