ESSAYS IN CRIMINAL AND FORENSIC PSYCHOLOGY NO.9

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1. TERRORISTS ARE JUST NORMAL PEOPLE DOING ABNORMAL THINGS?

1.1. INTRODUCTION

"At its core, terrorism is a form of social influence. It is a technique or tool used to influence public opinion and other political or social processes by enacting violence against a civilian population" (Stroink 2007 p293).

Terrorism is not necessarily straightforward to define. "In many cases, it is not so much the specific mode of violence as the underlying motivation that may lead to a crime being categorised as terrorism" (Mythen and Walklate 2006 p381). But any definition of terrorism needs to be careful not to "outlaw the struggle for self-determination" (McSherry 2005) [1].

Schmid (1983) performed a content analysis on 109 definitions of terrorism, and found 22 common elements. Table 1.1 shows the most common elements in the definitions.

MOST COMMON ELEMENTS	PERCENTAGE OF DEFINITIONS
1. Violence/force	83.5
2. Political intent	65
3. Fear/terror	51
4. Psychological effects	47
5. Reaction	41.5

Table 1.1 - Five most common elements in definitions of terrorism.

Taylor (2009) talked about extreme harm-doing like terrorism in terms of cruelty:

[1] Shamir and Shikaki (2002) found that definitions of terrorism can have a self-serving bias. They offered Israeli Jews, Israeli Arabs, and Palestinians eleven incidents of violence to define as terrorism or not. The decision tended to vary depending if the ingroup were the perpetrators or victims.

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> Yet cruelty encompasses far more than these rare horrors. Bullying at school and in the workplace, the criticism of celebrities and politicians in the media, and abuse within families can all be viciously cruel, if less spectacularly lethal. These examples are much closer to home; for some they are a painful part of daily life. Few if any of us have never been on the receiving end of some form of social cruelty: the cutting comments or sniggers or sidelong glances which so expertly demolish self-esteem. Few of us, in truth, have avoided being cruel ourselves (p6).

Taylor (2009) emphasised that in understanding "human harm-doing", cruelty is thus common, and it is the matter of degree in behaviour that is the focus. For example, "the difference between someone hurling verbal abuse at an immigrant and someone beating an immigrant to death is a difference of degree, not a difference in kind. This is not to say, of course, that the two are the same. Clearly, a mourner fighting back tears at a funeral is very different from a mourner sobbing uncontrollably — yet both are displaying the same type of emotion. We can imagine a continuum, from little or no grief to soul-destroying anguish, on which we could place the two bereaved" (p7).

1.2. NOT MAD OR CRIMINAL?

After the 9/11 attacks, one US politician said: "Those who would commit suicide in their assaults on the free world are not rational and are not deterred by rational concepts" (Atran 2003 p1535).

Silke (2003) noted that "Rumour and innuendo dominate our perceptions of suicide terrorists. In Israel, sections of the media push the idea that suicide bombers take drugs or alcohol before going to their deaths. Similar claims were made centuries ago about another Islamic sect of suicide attackers, the Assassins, but just as then, the stories are untrue".

Generally in understanding violent behaviour, habitual criminal tendencies or mental disorders are proposed as underlying causes. But this does not hold for terrorists. Put another way, "Terrorist groups are not usually composed of violent people, but people who choose to use violence as a tool to what they see as a reasonable end" (Colvard 2002).

For example, Sageman's (2004) study of 172 members of a fundamentalist Islamic group associated with Al Qaeda found little previous criminal behaviour before the involvement in terrorism. Nor did the individuals show

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signs of major mental illness using DSM-IV criteria. Few suicide bombers, that have been studied, showed symptoms of mental illness, or drug and alcohol abuse (Bond 2005) [2].

Thus, Dernevik et al (2009a) said: "It is unsafe to assume that terrorist violence can be assessed or predicted using general prediction models developed and used with other forms of other criminal violence, particularly models derived from work with mentally disordered offenders" (p511).

Though Janke (1992) rejected mental illness as a cause of terrorism, he noted that when offers of settlement are made many hard-liners resist - "for some, terrorism seems to have become a way of life [3] - a situation that would be impossible if something in the personalities of those involved did not demand it" (p185). Yet Janke (1992) admitted: "the personality characteristics commonly found in terrorists could equally have produced, for example, mountaineers, actors or politicians - all callings in which the ambition to rise above others, literally or figuratively, can be present" (pp188-189). So the group/environment is important in channelling such individuals in one direction and not the other.

A number of generally quoted causes are also not common among terrorists studied - childhood trauma, authoritarian personality, paranoia, poverty, and poor education (Dernevik et al 2009a). Interviews with failed suicide bombers in the Middle East find them to be statistically normal for their society in terms of education (ie: not illiterate or poorly educated), socio-economic status (ie: not from extreme poverty), personality, and religious beliefs (ie: no more devout than their general population), nor are they fatherless, friendless or jobless (Atran 2003) [4].

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[2] Grimland et al (2006) pointed out that "it should be noted that no clear evidence of psychopathology does not mean that suicide terrorists are 'sane' or without major psychological disturbance that might be detected if there were an opportunity to evaluate them" (p109).

[3] It could be argued that since the fight against the Soviet invasion of Afghanistan there has developed a pool of "jihadi" who move from "cause" to "cause". Abdul-Ahad (2010) reported the story of "Hamza" (Saudi Arabian) who has wandered around the world fighting in various "jihads" in Afghanistan, Bosnia, and Tajikistan among others.

[4] In terms of suicide bombers, Grimland et al (2006) distinguished between "those who are ready to die, those who seek to die, and those who are indoctrinated into suicide".

1.3. CAUSES OUTSIDE THE INDIVIDUAL

Borum (2003) felt that there was no such thing as a "terrorist personality" nor an accurate profile of the terrorist. The context of the action is thus more important: "terrorist acts and the causes that drive them can only be understood in relation to social, historical, political, and other factors" (Dernevik et al 2009b p521).

Arboleda-Florez (2006) agreed: "Historical, ancient cultural, and religious elements as well as contemporary national and economic grievances for the group, not just the individual perpetrator, will have to be factored in along with the push for exclusionism and expansionism of fundamentalism religious groups" (p517).

Bandura (1998) focused on how acts considered unacceptable in one context (ie: killing ordinary people) becomes acceptable for terrorists by the combination of psychological processes that give moral justification for the behaviour, and dehumanise and blame the victim [5]. Such psychological processes involve self-deception, but only as a variation on the everyday use of them.

Borum (2003) described four stages in social cognition that underpin terrorist thinking:

- The perception of unfairness in a particular political context.
- The perception of unfairness linked to one group in relation to others.
- The attribution of the blame for the discrepancy on one group.
- The attribution of the blamed group as evil.

I would also add that the "fetishism of the victim" gives incredible power and justification in individuals who believe that they are members of a group who are victims of great injustice. Silke (2003) was clear: "the raw ingredients that impel a young man to kill in the name of a cause are simple: anger and a sense of outrage. Religious leaders may communicate outrage, but, ultimately, theirs is not always the decisive voice in the bomber's motivation" [6].

Bond (2005) preferred to focus on the organisations

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[5] Bandura (1998) listed five elements - moral justification, displacement of responsibility, disregard for the consequences, dehumanisation, and attribution of blame.

[6] Rogers et al (2007) pointed out: "Religion might appear to play an elevated role because of the rhetoric used by terrorist groups, but the key factors driving the choice of suicide bombers researchers have shown to be low self-esteem combined with concrete grievances" (p2).

that recruit individuals for terrorism and suicide terrorism. Such organisations find individuals (usually young males) who are sympathetic to the cause and organise them into small groups ("cells"). Then use indoctrination (religious or political ideology; appendix 1A) to emphasise "the heroic nature of their mission and the nobility of self-sacrifice". Also encourage commitment to the small group in different ways including public declarations.

Commitment to the group for potential suicide bombers includes making concrete preparations for their death including taped messages to be seen/heard afterwards by the general public (reasons for bombing) or by loved one (not to mourn as not dead but transformed). Isolation from wider society within the group means that irrational beliefs and behaviours become accepted as rational.

Salib (2003) applied the idea of "folie à deux" ("madness of two") or "folie à plusieurs" ("madness of many") to this situation. These are terms that refer to shared delusions among individuals who live in close proximity and isolated from the outside world. A powerful figure, like the organisation's leader, can initiate and sustain the irrational beliefs.

Colvard (2002) added "the network of psychological and ideological legitimacy" which supports terrorist groups literally and morally.

The active terrorists are only a minority of a community or group. All members of that community or group share common features, so the question could be what leads some individuals in that community or group to become active (Rogers et al 2007) (figure 1.1). Silke (2006 quoted in Rogers et al 2007) emphasised a catalyst event (eg: killing or injury of close friend or relative by perceived enemy) that produces the transition from "member of disaffected group to a violent extremist". Rogers et al (2007) stated that grievances and threats are insufficient in themselves as the causes of terrorism. Silke also added "a pre-existing cultural acceptance or precedence for self-sacrifice or martyrdom in conflict, the existence of a long-term or long-running conflict involving multiple casualties on both sides, and the fact that the protagonists do not believe that victory is within their reach" (Rogers et al 2007 p5).

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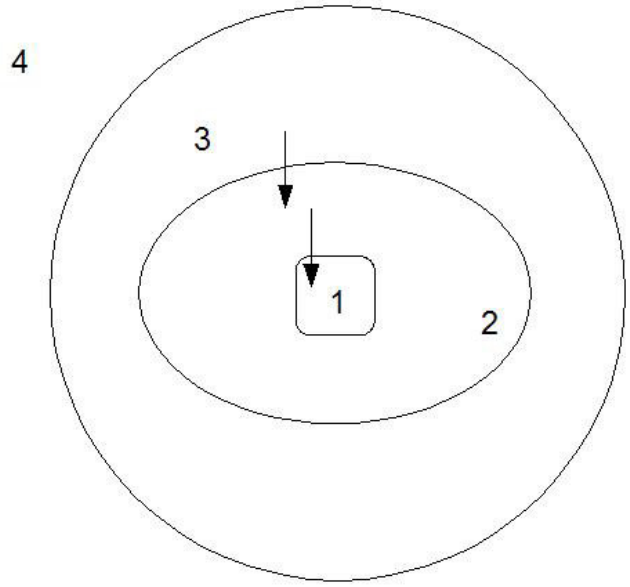

1 = Active terrorists/violent extremists
2 = Direct supporters of 1, but not active themselves
3 = Passive supporters of 1 (do not directly support, but do not criticise either)
4 = Members of community not involved

Figure 1.1 - Active terrorists and supporters in a community or group.

1.4. SOCIAL IDENTITY

Stroink (2007) highlighted three categories of factors from the research on individuals turning to terrorism:

i) Context factors - The political and historical context of the situation, and the psycho-social conditions (eg: perceived deprivation or insult against the ingroup).

ii) Process factors - This focuses upon the process by which an individual becomes a terrorist, like socialisation by peers ("gradual process of incremental involvement"; Horgan 2005).

iii) Identity factors - The process of identifying with a particular ingroup, and the consequent discrimination against other groups (as described by social identity theory; Tajfel 1981; appendix 1B).

Using psychoanalytic ideas, the Group for the Advancement of Psychiatry (1978) described the real or imagined threat to the ingroup perceived as the danger of

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humiliation of the self. This produces a narcissistic rage which turns into the violence involved in terrorism. Add to this the licence given by the group sanctioning such action. But this behaviour is no different to non-terrorist violence: "When one's country is slighted, the narcissistic rage is labelled patriotism or loyalty, and the individual's motives are, therefore, never questioned" (Grimland et al 2006).

Though many factors are involved, Stroink (2007) concentrated on social identity in understanding second-generation immigrants in the West who turned to terrorism (the so-called "homegrown terrorists"). Some of these individuals will have identified with the mainstream culture and others will not. In the former case, a parallel can be drawn with "reactionary terrorism" in the USA (eg: Oklahoma City bombing), where "the individuals involved hold a construal of their culture, often one associated with a prior 'golden era', that they believe to be under threat by various internal or external forces of change" (Stroink 2007 p300). So, terrorism in this case relates to disappointment with the ingroup.

Individuals who have not identified with the mainstream culture are similar to international terrorists. Such second-generation immigrants may identify with another culture or group. For them, it is not just that the cultures/groups are different, but that they are incompatible.

A third group of second-generation immigrants involves those who identified with the mainstream culture and then ceased to do so - "the interesting paradox of having someone turn an ingroup into a hated outgroup" (Stroink 2007 p303).

1.5. CONCLUSIONS

The disturbing fact is that most extreme acts of violence are committed by people who would be classed as normal in mental health terms (Waller 2007). Bond (2005) noted that the "immediate reaction to suicide bombers is to label them as animals, or inherently evil. But this will not do. Blowing themselves up in a crowd is often the first evil thing these people have dome. And they are not animals. The most difficult thing of all is to recognise that suicide bombers are, alas, all too human". A UN researcher working in the Palestinian territories is quoted in Silke (2003) as saying: "what is frightening is not the abnormality of those who carry out the suicide attacks, but their sheer normality. They are so normal

for their communities and societies" [7].

Brewer (2006) used the phrase "human being theory" to emphasise the need to see perpetrators of extreme acts as human beings not "animals". Such individuals are "rational" social actors and their behaviour makes sense to them (ie: an internal logic for their behaviour) [8].

In terms of the causes of terrorism, "As Reich (1998) so aptly stated, 'No single psychological theory, and no single field of scholarly study' can completely explain the motivations of terrorist individuals and groups" (Rogers et al 2007 p8) [9].

1.6. APPENDIX 1A - FUNDAMENTALISM

At the moment, many of the terrorist acts reported in the media are associated with religious beliefs, and, in particular, fundamentalism [10]. Rogers et al (2007) questioned whether fundamentalist beliefs were evident in all terrorist cases as "no-one has managed to do this kind of research so we cannot be sure whether there is any grain of truth in the proposal that terrorists are fundamentalists, compared to other people" (p7).

It may not be the fundamentalist versions of a particular religion or political ideology specifically, rather it is a mind-set that is associated with that thinking - namely, the "certainty of simplicity" ("us-good versus them-bad"; Rogers et al 2007).

In terms of religion specifically, Allport and Ross (1967) distinguished between extrinsic and intrinsic religiosity. The latter is where religion gives meaning to the individual's life, while the former is "strictly utilitarian: useful for the self in granting safety, social standing, solace, and endorsement for one's chosen way of life" (Allport 1966 quoted in Rogers et al 2007). The important implication is that individuals high on

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[7] Lanning (2002) observed that "if the psychodynamic approach is to help us understand the psychology of terror, it will do so not by showing how terrorists are different from us, but how they are the same" (quoted in Rogers et al 2007 p2).

[8] Post (1998) referred to a "psycho-logic" constructed to rationalise the violence. "As a result, terrorist dialogues contain strong elements of 'us vs. them', where the group defines 'us' as freedom fighters, fighting for a just cause, and 'them' as the source of all evil. Therefore, it is only logical that the destruction of 'them' becomes a moral obligation because, '. . . if "they" are the source of our problems, it follows ineluctably, in the special psycho-logic of terrorists, that ‘‘they’’ must be destroyed' (Post 1998 p25)" (Rogers et al 2007 p3).

[9] In Brewer (2003), I applied a synthesis model to combine the different types of explanation for such behaviour.

[10] Moghissi (1999) described the characteristics of Islamic fundamentalism as anti-modernity (but not necessarily modernisation; ie: material progress), anti-democracy, and anti-feminism, though these could be applied to fundamentalism generally.

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extrinsic religiosity will be more close-minded, and likely to show prejudice towards other groups.

1.7. APPENDIX 1B - SOCIAL IDENTITY THEORY

The basis of the social identity theory is the tendency to classify people and things into categories, which leads to an exaggeration of the differences. Tajfel and Wilkes (1963) asked participants to judge the length of groups of lines either labelled (eg: A or B) or unlabelled.

There was a tendency to judge the labelled lines as similar (eg: lines within group A) and exaggerate the differences to other groups, even though this was inaccurate. Stereotypes can also be involved in this process.

At the same time as categorising behaviour, individuals search for positive self-esteem by assessing their social groups as "better" than others. It feels good to belong to the best group, whatever that group may be. It is the mere perception of the existence of another group that matters. This is known as the minimal group effect.

The original and main study is Tajfel (1970). Using 64 14-15 year-old Bristol schoolboys, they were randomly allocated to one of two groups (for example, by preference for abstract paintings by Klee or Kandinsky; or tossing a coin). There was no reference to group identity: the individuals were anonymous, and doing the experiment in individual cubicles. There was no obvious self-interest involved.

The boys were then asked to allocate points as rewards to different individuals for no particular reason.

It was found that the majority of boys gave greater rewards to individuals in their own groups; ie: they used "maximum ingroup profit" and "maximum difference" strategies.

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2. DID HE DO IT? STATISTICS AND PROBABILITIES

In a court case the jury is often faced with forensic evidence, and this tends to be presented in terms of statistics and probabilities. Probability (or conditional probability) is based on the ideas of Thomas Bayes, and calculates the chance of one thing being true if that depends on other things being true as well.

Misunderstanding what the number mean can have major implications. For example, Denis John Adams was convicted of rape in 1996, and the jury was influenced by a DNA match in the semen present at the crime scene and Adams of 1 in 200 million [11] (though he was not identified and he had an alibi [12]). The figure was interpreted as a 1 in 200 million chance that the semen at the crime scene belonged to someone other than Adams. But it actually means that there is a 1 in 200 million chance that the DNA of any random member of the public will match that found at the crime scene. So with a population of 10 000 men who could have committed the crime, for example, that would be 10 000 in 200 million (1 in 20 000) chance that someone else is a match too (Saini 2009) [13].

There are a number of mistakes that can be made when using probabilities in the legal system (Saini 2009):

1. The prosecutor's fallacy (or source probability error).

When faced with a piece of forensic evidence and probabilities, there are two possibilities: (a) the probability that someone is innocent if they are a match to a piece of evidence, or (b) the probability that someone is a match to a piece of evidence if they are innocent. Most jurors assume (a) when forensic evidence presents (b).

For example, in the 1991 rape trial of Andrew Deen in the UK, the figure of 1 in 3 million was quoted in relation to the semen sample at the crime scene. It was

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[11] This is known as the "match probability" - "the probability that if you pick someone at random, their DNA would match the DNA sample of the assailant" (Donnelly 2005 pp46-47).

[12] "The police had no leads at the time, but quite some time later the woman thought she saw the man who had raped her walking along the street. She called the police, but by the time they arrived he had gone. Some time later again, the police came up with a suspect, Denis Adams, and arranged an identity parade. The victim didn't pick him out. At the committal hearing, he was pointed out to her and she was asked if he matched her description, and she said no. She had described a man in his early 20s, and when asked how old Adams looked to her, she said around 40 (he was in fact 37)" (Donnelly 2005 p46).

[13] This is an example of "the prosecutor's fallacy".

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assumed that this figure referred to (a) above - the likelihood of the semen being any other man than the defendant was 1 in 3 million. But applying (b) above, 1 in 3 million was the likelihood that any individual in the general population had the DNA profile matching that at the crime scene. With sixty million people in the UK, a few individuals could have that DNA profile. However, the plausibility of those other people committing the crime is the issue (Saini 2009).

2. Ultimate issue error.

This is where the small probability is equated to an individual's vulnerability of being innocent.

For example, in the case of Malcolm and Janet Collins in Los Angeles in 1968, an elderly woman was robbed by a White woman with ponytail blonde hair and a Black man with a beard and moustache (driving a yellow car). A match to the defendants. The chances of finding another match other than the defendants was calculated as 1 in 12 million [14]. Thus the jury took the Collinses to be unlikely to be innocent. But in a city the size of Los Angeles, there are many couples matching the details (Saini 2009).

3. Base-rate neglect.

This is the mistake of ignoring the pool of possible matches ("base rate"). When the expert says that the chance of finding another DNA match between the crime scene evidence and the defendant are 1 in 10 million, say, that sounds damning. But in the UK population of 60 million that means there are six people while the same profile or more in a world population of billions.

In another case, an individual has tested positive on a test, say, with 1 in 1000 blood match probability, and the test is 99% accurate. They must be guilty? But the odds of guilt are low. There is a greater chance of

[14] The complete list of probabilities the prosecutor asked the mathematician to assume was:

- Black man with a beard: 1 out of 10
- Man with moustache: 1 out of 4
- White woman with blonde hair: 1 out of 3
- Woman with a ponytail: 1 out of 10
- Inter-racial couple in car: 1 out of 1000
- Yellow car : 1 out of 10

Based on these figures, the mathematician then calculated the overall probability that a random couple would satisfy all of the above criteria, which he worked out to be 1 in 12 million (Devlin's Angle at http://www.maa.org/devlin/devlin_07_08_07.html; accessed 14/11/10).

them being innocent than guilty irrelevant of the test finding. If the test is 99% accuracy, it means that it produces false positives for 1% of cases (ie: individuals not having profile but falsely found so by test). One percent of 1000 means that the false positives will outnumber the possibility of true positive for this individual (10 of 11 are false positives = 91% chance innocent) (Fenton and Neil 2008). The defendant may be a true positive, but that cannot be ascertained from that test.

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3. THE USE OF ELECTRONIC MONITORING OF OFFENDERS

3.1. INTRODUCTION

Electronic monitoring (EM) was first introduced in 1989 in England and Wales. It can be used as an alternative to a prison sentence ("front door" EM; Marklund and Holmberg 2009), particularly with enforced curfews during nights and leisure-time hours, as an alternative to pre-trial detention, or as part of parole (ie: use after release from prison) ("back door" EM; Marklund and Holmberg 2009). With the developments in EM technology and GPS (global positioning system) it is possible to monitor exactly where an offender is at any time.

The original technology uses radio frequency transmission which emits a signal to a receiver unit connected, by telephone line usually, to a central office. The EM device is usually worn on the leg in the form of an ankle bracelet.

3.2. EVALUATION STUDIES

If EM is to be used as an alternative to prison, say, then it is necessary to evaluate its effectiveness with research studies. Bearing in mind that techniques can have unexpected or unforeseen consequences (appendix 3A).

The Campbell Collaboration [15] have produced an ongoing meta-analysis of the evaluation of EM. Few studies have control groups and randomised designs which limits the ability to draw conclusions about its effectiveness. However, it was suggested that EM may be best as a replacement for prison for drink-driving offenders, or as part of a treatment programme with high recidivism risk offenders (Marklund and Holmberg 2009).

Renzema and Mayo-Wilson (2005) performed a meta-

[15] http://www.campbellcollaboration.org/.

analysis of studies of EM with high risk offenders (ie: risk of re-offending of at least 30%). Only three studies were found that were "good quality", and none found any benefits for EM compared to a comparison group.

Marklund and Holmberg (2009) evaluated the use of "back door" EM in Sweden with offenders released on parole after serving two-thirds of their two-year sentence. The participants had to have a place to live and a job, and checks for drug and alcohol use were included. Two hundred and sixty individuals were involved between 2001 and 2003, and they were compared to a matched group released from prison during the same period in a three-year follow-up.

Overall, 26% of the EM group were convicted of new offences in the follow-up period compared to 38% of the comparison group ($p<0.01$) (13% and 21% respectively were sentenced to a new prison term) (figure 3.1) [16]. This also compares to 15% which was the statistically calculated expected proportion of re-offending within the first year after release. The authors admitted: "It is not possible, however, to state to what extent this was a result of the electronic monitoring in the home or of the other elements included in the programme" (p41).

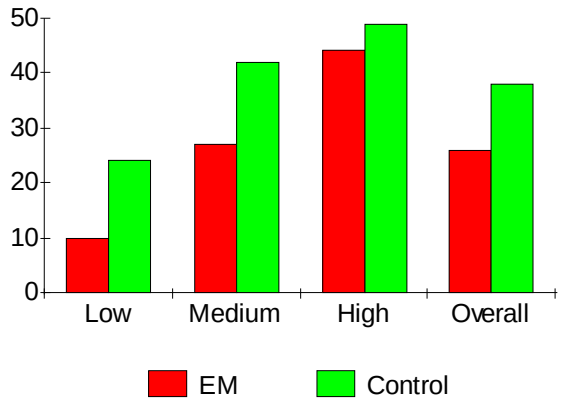

Figure 3.1 - Rates (%) of re-conviction in follow-up based on assessed risk of offender re-offending.

Killias et al (2010) investigated the effectiveness of EM compared to community service in Switzerland. Since the year 2000 offenders on short sentences have the option of non-custodial community service or EM in Vaud canton.

Two hundred and forty offenders who volunteered for

[16] Of the EM group, 11% were reconvicted in the first year of follow-up, 9% in the second year and 6% in the third compared to 15%, 17% and 6% respectively.

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a non-custodial sentence were randomly assigned to community service or EM between 2000 and 2002. Follow ups were made in 2006 and 2009 to assess reconvictions. With drop-outs, 106 individuals were put on EM and 116 on community service.

Reconvictions in the following three years after the non-custodial sentence was 21% for the EM group and 31% for the community service group using criminal records, but 41% for both groups based on self-reported new offences. In terms of "social integration" (eg: having a job) the EM group did better.

3.3. ADVANTAGES OF EM

1. Cheaper than prison.

2. Keeps the offender in their community, and allows to continue working as appropriate, but limits the opportunity for crime with curfews.

3. Allows individuals awaiting trial to be kept under surveillance without the need for detention.

4. A means of reducing the prison population.

5. More appropriate for minor offences than short-term imprisonment.

6. EM can be used in different ways from an alternative to prison, part of parole or probation, or as a means of supervision in domestic violence cases.

7. Offenders do perceive it as punishment and as a deterrent to future crimes (eg: Martin et al 2009).

8. Development in technology mean that it is effective, and not prone to breaking down.

9. Appropriate in specific crimes like a curfew during a football match for individuals convicted of football-related violence.

10. Benefits to offenders being forced to spend more time in the house with their family.

3.4. DISADVANTAGES OF EM

1. Offenders may still be able to commit crimes if not complete house arrest.

2. It does not necessarily protect society if not

complete house arrest.

3. Does not involve punishment like working as part of community service simply being at home during a curfew.

4. Not appropriate for certain crimes where incarceration is required or for long-term sentences.

5. Questions about the effectiveness of technology.

6. It is possible for offenders to sabotage the device.

7. Not rehabilitating the offender unless used with other programmes.

8. Still the risk of exposure to peers and the negative influences of others (though this is a problem in prison too).

9. Enforced contact with the family may not be helpful.

10. The "civil liberty argument" against the use of such devices.

3.5. APPENDIX 3A - UNEXPECTED CONSEQUENCES

Programmes that appear to be common sense good ideas can have unexpected or unforeseen side effects. Take the example of regular, random urine samples in prison to check for drugs as the means to reduce drug-talking. Began in 1995 in England and Wales, a positive test is punished with extra days added to the sentence, for example (Muir 2008).

In a pilot study in eight prisons it was found that the taking of harder drugs (opiates and benzodiazepines) increased 80% with the advent of testing (table 3.1). Many prisoners changed from cannabis (detectable for up to three weeks - ie: half life of 14-21 days) to heroin (detectable for only three days) to "beat" the test (Gore et al 1996).

	TOTAL NUMBER OF DRUG TESTS	NUMBER OF POSITIVE TESTS FOR CANNABIS (%)	NUMBER OF POSITIVE TESTS FOR OPIATES & BENZODIAZEPINE (%)
February-May 1995 (testing first introduced)	1089	362 (33.2%)	44 (4.1%)
June-December 1995	2282	663 (29.1%)	168 (7.4%)

(Source: Gore et al 1996)

Table 3.1 - Number of positive drug tests.

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4. HAROLD SHIPMAN AND MEDICAL SERIAL KILLERS

4.1. INTRODUCTION

Dr. Harold Frederick Shipman killed many of his patients in northern England in the last few years of the twentieth century [17]. Because he refused to talk in custody, it has only been possible to estimate the number of murders [18]. An inquiry between July 2002 and January 2005 headed by Dame Janet Smith [19] considered all 888 cases who had died while being a patient at Shipman's General Practice. Smith concluded that 215 cases [20] were definitely killed by Shipman, another 45 were probably also, and 200 more were suspicious (Gunn 2010) [21] [22].

It is also not clear when the first murder occurred (possibly March 1975), and he was arrested in 1998. These limited details highlight the problem of knowing the truth about Shipman, including his motivations for the murders.

"Medical serial killer" is a sub-group of serial killers or murderers generally, and is sometimes called "clinicide" (medical murder) (Kaplan 2007) or, a more general term, "caregiver associated killing" (Yorker et al 2006).

Holmes and DeBurger (1988) outlined four "types" of serial killer:

- Visionary - This individual is responding to voices (auditory hallucinations) telling them to do the killings.

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[17] He was convicted of murdering fifteen patients at Preston Crown Court on 31st January 2000 (Soothill and Wilson 2005).

[18] Shipman had a "role model" in the form of GP, John Bodkin Adams, who in Eastbourne, southern England, was involving in "easing the passing" of possibly up to 400 older women in the 1950s. His motivation seems to have been more about money as he appeared in 132 wills of these women (Kinnell 2000).

[19] Report at http://www.the-shipman-inquiry.org.uk.

[20] 171 women and 44 men (Soothill and Wilson 2005).

[21] Kinnell (2000) described it as "serial euthanasia".

[22] In 1997, for example, Shipman was responsible for 6% of all homicides in England and Wales (Gilleard 2008).

- Mission-oriented - This individual believes that the killings serve a purpose (eg: a moral cleansing by murdering street prostitutes).

- Hedonistic - Here there is pleasure and benefits (eg: financial) from the killings.

- Power/control-oriented - There is sexual arousal from the murder ("sexual homicide") with control being important.

Shipman could be placed in the mission-oriented" or "hedonistic" categories. There is no evidence for the other two types. In terms of the "mission", most of the victims were elderly (and some had chronic health problems), did Shipman view himself as a "mercy killer"? Did he believe that he was saving these individuals from the suffering to come as their health deteriorated? In terms of the hedonistic category, it is assumed that he gained pleasure from the killings, though he does not seem to have gained financially. Though he was caught when attempting to forge a victim's will in his favour.

Rossmo (1997) has distinguished four types of "victim search method" (ie: ways to find victims) and three types of "victim attack method" used by serial killers (table 4.1). Shipman can be categorised as a "trapper" and "ambusher".

Victim Search Methods

- Hunter - offenders who set out specifically to find a particular type of victim close to their own home.
- Poacher (or "commuters") - offenders who set out specifically to find a particular type of victim but away from their homes.
- Troller - this involves an opportunist encounter with a victim while doing something else.
- Trapper - the offender who works in a particular job to allow them the opportunity to encounter victims within their control.

Victim Attack Methods

- Raptor - attacks victim upon meeting.
- Stalker - who follows victim and then attacks them.
- Ambusher - attacks only when victim is in situation controlled by the offender, like the offender's home.

Table 4.1 - Types of victim search and attack methods.

4.2. WHY DID HE DO IT?

The big question is why did Shipman do it? Janet Smith, at the end of her official inquiry, said: "I think

it likely that whatever it was caused Shipman to become addicted to pethidine also led to other forms of addictive behaviour. It is possible that he was addicted to killing" (quoted in Gunn 2010 p195). While popular explanations focused on him enjoying the control over life and death.

There were a number of factors in his life that appear to have contributed (when combined together rather than individually). These included:

- A very intimate relationship with his mother, but not close to his father.
- Pressure from his mother to succeed academically.
- His mother died of cancer when he was seventeen, and he spent many hours by her bedside including for the last breath.
- Not good at expressing his emotions. When his died, he "ran out of the house into the rain, and kept running. He returned to school the following Monday as if nothing had happened but, when asked about his weekend, said only that it hadn't been too good because his mother had died!" (Gunn 2010 p190).
- Made girlfriend pregnant during medical school and agreed to marry her while she studying.
- Abused pethidine (meperidine) in early career, and was fined by a court and suspended from practising as a doctor in 1976 (which he seems to have ignored). Generally little action was taken by the authorities as no patients had come to harm (Gunn 2010).

He was a popular GP (general practitioner) among his patients with a reputation as a good and caring doctor [23]. Simple and popular explanations for extreme behaviour prefer to see the individual as wholly bad, and struggle with contradictions. Kernberg (1984) described the personality type of "malignant narcissism", where the individual shows the obvious narcissism and grandiose self-importance including delight in getting the better of "officials" and humiliating those seen as "inferior". There is also paranoia and anti-social behaviour shown, but this personality type includes a capacity for loyalty and concern for others.

At a sociological or social level of analysis, Leyton (1986) has proposed the idea of "homicidal protest" to explain serial killing. Frustrated members of

[23] "Dr.Shipman was described as having 'almost celebrity status' amongst his elderly patients, primarily because he gave them extra time in his surgery, was always willing to visit them at home and made them feel 'that he was a real friend' to them" (Gilleard 2008 p89).

the upper working and lower middle classes "punish those above them in the system". Soothill and Wilson (2005) felt that this idea was not appropriate for Shipman because his elderly victims were not "above him" in the system (apparently). But "homicidal protest" could be seen as "a form of revenge.. that is wreaked upon relatively powerless groups in society" (p695).

Add to this social change:

> Over Shipman's lifetime, Britain became a more secular society. The sanctity of life is less preserved by religious conviction. In contrast, doctors, both in appearance and reality, are increasingly becoming the moral arbiters of life. Shipman was simply demonstrating this power in an outrageous way (Soothill and Wilson 2005 p697).

Gilleard (2008) preferred to understand the murders in the context of the victims being old and society's view towards older people and death:

> In short, Dr.Shipman was able to get away with killing many of his patients primarily because most deaths of people aged 65 and over are seen as 'natural deaths', deaths that conform to the natural order, and so need not be prevented...[] the public acceptability of these deaths – deaths that took place quickly and quietly at home. We have come to consider as unlawful deaths that occur in public places – shootings in clubs and pubs, stabbings on the streets, drive by shootings and massacres in shopping malls. If not they are hidden, the discovery of the dead body itself prompting investigation. Corpses are found behind closed doors, buried in fields and gardens, hidden beneath the floorboards or bricked up in cellars. This is what murder is supposed to look like, deaths far removed from the naturalness of people silently dying in hospitals, nursing homes, hospices and other sites of care (pp91-92)

In other words, Shipman's and his victims were not typical of many serial killers generally, for example:

- He was older.
- He was able to function socially.
- He did not use violence.
- The victims were not randomly chosen.
- No over sexual motivation.
- He was not psychotic.

4.3. MEDICAL SERIAL KILLERS

One question that has arisen is whether Shipman was unique in the sense that doctors do not murder patients, or that he is the (extreme) tip of an iceberg where it happens more frequently (and usually unnoticed).

Kinnell (2000) observed that "medicine has arguably thrown up more serial killers than all the other professions put together, with nursing a close second", and "there are enough recorded instances of multiple murders by doctors (real or bogus) to male at least a prima facie case that the profession attracts people with a pathological interest in the power of life and death" (p1594).

Yorker et al (2006) searched for all healthcare givers charged with homicide between 1970 and 2006 using a legal cases database [24]. They found 2113 suspicious deaths in the care of doctors and nurses in 147 cases with ninety healthcare professionals. But 54 were convicted cases, of which seven were doctors (table 4.2). The majority of cases (86%) were nursing professionals.

DOCTOR	COUNTRY	COURT CASE	DETAILS
Harold Shipman	England	2001	Convicted of 15 murders, but many more suspected
Joseph Michael Swango	USA (and other countries - eg: Zimbabwe)	2000	Charged with 5 murders and convicted of one; 126 suspicious deaths in various countries
Mechthild Bach	Germany	2004	Inquiry into 76 suspicious deaths
Two male doctors	Poland	2004	Charged with 5 deaths to receive payment from funeral parlour (up to 5000 suspected)
Four doctors	Russia	2004	Multiple patients to gain organs for transplant market
Howard Martin	Wales	2004	Charged with 3 murders but acquitted
Robert Allen Weitzel	USA	2002	Convicted of five murders but overturned

(Based on Yorker et al 2006)

Table 4.2 - Seven cases of multiple murder by doctors between found 1970 and 2006 found by Yorker et al (2006).

[24] They excluded cases involving murder by healthcare professionals outside the healthcare setting (eg: domestic), single murders, and assisted suicides with full consent.

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5. ANGER MANAGEMENT PROGRAMMES WITH OFFENDERS AND "EMOTION TALK"

5.1. PRINCIPLES OF ANGER MANAGEMENT PROGRAMMES

As a generalisation prison inmates have higher anger scores on whatever measurement scale is used than the general population, and violent offenders have higher scores than non-violent offenders (Howells et al 2005). The assumption behind these concerns is that anger consistently leads to aggression.

But "Anger is neither a necessary nor a sufficient condition for aggression and violent crime. Violent acts can occur without anger being a significant antecedent, as in some 'psychopathic' offenders. Equally, the vast majority of episodes of anger do not culminate in violence.." (Howells et al 2005 p297).

Anger management programmes are based on the principles of cognitive behavioural therapy (CBT), which emphasises controlling the thoughts (cognitions) that lead to a behaviour.

The original idea for these programmes comes from Raymond Novaco (1975), who emphasised the role of cognitions in anger (ie: thoughts precede anger or aggression).

The expression of the anger becomes reinforcing, and a pattern is set for future behaviour. But anger is not necessarily all bad; it is a question of managing it, and self control.

Anger control programmes tend to be based on three stages:

i) Cognitive preparation - careful analysis of anger patterns allows the individual to recognise their own patterns. In particular, to identify triggers, and then to follow the process.

ii) Skill acquisition - this stage involves the teaching of techniques to use when the triggers for anger come. This could include self awareness that an anger-provoking situation is developing, and using self talk to stop the aggressive reaction. Other skills could include

relaxation training, assertiveness training, and social skills training.

iii) Application practice - this last stage involves creating stressful situations which provoke anger, so that the newly learned techniques can be applied. There is then an assessment of how the situation was handled by the individual themselves and the therapist.

5.2. EVALUATION OF PROGRAMMES

The efficacy [25] of anger management programmes in reducing anger and anger-related problem behaviours can be assessed in three ways (Howells et al 2005):

- Absolute efficacy - where anger management is compared to no treatment. Studies show support for a modest benefit (eg: DiGiuseppe and Tafrate 2003).

- Relative efficacy - where anger management is compared to another treatment. A limited number of studies here which hinder a conclusion (DiGiuseppe and Tafrate 2003).

- Component efficacy - which assesses the element of a programme (eg: relaxation training) that is most efficacious.

For example, Howells et al (2005) found limited absolute efficacy for a brief anger management programme with offenders in South and Western Australia. The programme involved ten sessions, each lasting two hours, focusing on identifying triggers for anger, developing skills to combat the triggers, and relapse prevention. The self-reported and staff-reported measures of aggression were taken before the treatment and after for both the participants and the waiting list controls. Both groups showed slight improvements over time, but there were no statistically significant differences found.

But offenders who were motivated and ready to deal with their anger problems showed the greatest improvements in the treatment group, and the poorly motivated the least or no change.

Howells et al (2005) listed some key weaknesses of anger management programmes which could account for their findings:

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[25] Efficacy" of the treatment means the outcomes under ideal conditions, while "effectiveness" is how well it works under practice conditions (Zito and Provenzano 1995).

i) The content of the programmes are too complex for the limited programme time. For example, in Canada the programme runs for 100 hours.

ii) There are limited opportunities for offenders to practice the skills learned on the programme.

iii) Offenders can have multiple problems which need to be addressed (eg: Anti-Social Personality Disorder, substance abuse, limited verbal skills) not just the anger.

iv) The problems of the environment - eg: resentful, distrustful and combative style of some offenders in group therapy settings.

Walker and Bright (2009) added these criticisms of studies which evaluate the effectiveness of anger management programmes:

a) The length of the programmes vary from two 30-minute sessions to over ten hours in eight sessions.

b) The use of participants who are not prisoners or offenders (eg: schoolchildren, university students).

c) The use of self-reports of anger and violence only as the outcome measure.

Walker and Bright (2009) felt that there is support "for anger management as an effective intervention for schoolchildren, but there is insufficient reliable high-quality evidence to justify the widespread use of anger management in prison" (p176).

5.2.1. Theoretical Challenges

Walker and Bright (2009) argued that anger management techniques needed to be combined with psychodynamic ideas to deal with the fragile inner sense of self-esteem that underlies violence. For them, a protection of low self-esteem [26] in the face of humiliation is the cause of much violence. "Psychoanalytically, violence is seen to be a way of ejecting unmanageable negative affects and attempting to cause them in the victim" (p176).

[26] A "false inflated self-esteem": "extreme low self-esteem (covered by apparent macho arrogance) underpins the recourse to and maintenance of violent and aggressive behaviour, then self-esteem building should form a central focus of the work" (Walker and Bright 2009 p187).

At a wider level there is also the issue of the nature of anger. Traditionally, anger (or any emotion) is viewed in psychology as existing in an objective sense, but discursive psychologists prefer to focus on "emotion talk". "Emotion is not treated as a psychological phenomenon that needs to be pinned down and classified, but rather as a conceptual resource deployed for conversational purposes" (Parkinson 2007 p111).

Cognitive theories of anger concentrate on the "cognitive script" involved (ie: how an anger episode typically unfolds), whereas the discursive approach is interested in how talking about anger is used in interactions (appendix 5A).

5.3. APPENDIX 5A - "EMOTION TALK"

Emotions are usually seen as "natural bodily experiences" whereas Edwards (1999) argued that language constructs such experiences as individuals talk about their "emotions" in "emotion talk". This construction process is involved in managing accountability. "The conceptual repertoire of emotions provides for an extraordinary flexibility in how actions, reactions, dispositions, motives and other psychological characteristics can be assembled in narratives and explanations of human conduct" (Edwards 1999 p288).

This is the individual's explanation for their behaviour in terms of responsibility or control over it, depending what they are arguing (ie: how they are positioning themselves - eg: "the anger just took hold of me"). Edwards (1999) outlined a number of dichotomies involved - eg: justified versus unjustified - anger as an appropriate reaction to an event or not.

Walton et al (2004) explored the discourses used by men talking about their emotions in focus groups. One scenario discussed was another man trying to chat up a man's girlfriend at a nightclub while he was present. It was felt that the boyfriend had "to do something" as it was expected of them as a "man". Men using aggression in such situations in embedded in the cultural conceptions of masculinity, which, in this case, were "drawing upon themes of ownership and entitlement". In such a situation, the "appropriate" reaction "might allow men (or, given the specifics of the scenario, heterosexual men) to 'do' anger as physical violence" (Walton et al 2004 p410).

Yet, at the same time, there are discourses of "coolness" for men: "Thus, whilst violence is accepted as a standard masculine response to other men's infringement of entitlements over girlfriends, Brian [speaker in group] is able to construct himself as not resorting to

violence and to position himself as masculine through the invocation of masculine control over emotional expression" (Walton etal 2004 p411).

What the discursive approach to emotions shows is that they are not individual experiences, and the issue is not to control them or not. Emotions are embedded in social contexts and cultural expectations, and this is a fundamental challenge to the effectiveness of anger management programmes. In other words, it can be expected that a man must be violent in some situations to show that he is a "man". If this is a socially accepted view, then no amount of anger management training will stop this.

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